



**USAID**  
DEL PUEBLO DE LOS ESTADOS  
UNIDOS DE AMERICA

**PERU | POLITICAS  
EN SALUD**

USAID **50** ANIVERSARIO

## **Balance on Health Institutional Decentralization**

### **USAID/Peru/Políticas en Salud**

**Contract No. GHS-I-10-07-00003-00**

Revised Draft

October 15, 2011

*Prepared for:*

**Luis Seminario, COTR**

USAID/Peru Health Office

Av. Encalada s.n.

Lima - Perú

*Submitted by:*

**Abt Associates Inc.**

4550 Montgomery Avenue

Suite 800 North

Bethesda, MD 20814

This document has been elaborated by USAID|Peru|Políticas en Salud Project, financed by the United States Agency for International Development (USAID) under contract No. GHS-I-10-07-00003-00.

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

## Balance on Health Institutional Decentralization

### Table of Contents

<b>Acronyms .....</b>	<b>iii</b>
<b>RESUMEN EJECUTIVO .....</b>	<b>vii</b>
<b>EXECUTIVE SUMMARY .....</b>	<b>ix</b>
<b>1. Introduction.....</b>	<b>1</b>
1.1 Objectives of this Report.....	1
<b>2. Health Decentralization Framework.....</b>	<b>2</b>
2.1 Health Decentralization Background .....	2
2.2 Start-Up Situation in the Health Sector .....	5
2.2.1 Situation within the Ministry of Health .....	5
2.2.2 Situation in the Regions.....	9
2.3 Conceptual and Analytical Framework of the Institutional Decentralization .....	15
2.3.1 Institutional Decentralization Components.....	16
2.4 Regulatory Framework for Institutional Reordering .....	19
2.4.1 Decentralization Policy Legal Framework .....	19
2.4.2 Regulatory Framework for the transference of Responsibilities .....	23
2.4.3 Regulatory Framework for Institutional Adaptation .....	29
<b>3. Processes for Responsibility Transference in Health .....</b>	<b>39</b>
3.1 Delimitation of Health Competencies .....	39
3.1.1 Delimitation of Competencies in the 2002 - 2006 Period .....	41
3.1.2 Delimitation of Competencies in the 2006-2011 Period .....	46
3.2 Transference of Competencies and Functions .....	53
3.2.1 Health Transferences in the 2004-2006 Period.....	57
3.2.2 Health Transferences in the 2006-2011 Period.....	62
3.3 Progress and Limitations of the Transference Process of Responsibilities.....	64

<b>4. Institutional Adaptation Processes of the Health Sector in Regional Governments .....</b>	<b>68</b>
4.1 Organizational Adaptation Processes of the Health Sector in the Institutional Design of the Regional Government .....	68
4.1.1 Change Processes in the Organizational Location of the Health Sector within the Regional Government .....	71
4.1.2 Processes of Organizational Adaptation within Health Directorates .....	79
4.1.2.1 Organizational Adaptation of the Administrative Headquarters of DIRESA .....	79
4.1.2.2 Organizational Arrangement of Health Networks .....	90
4.2 Institutional Capacity Building Processes .....	97
4.3 Advances and Limitations of the Institutional Strengthening and Adaptation Process .....	103
<b>5. Conclusions of Health Institutional Decentralization .....</b>	<b>109</b>
5.1 Results of Health Institutional Decentralization .....	109
5.2 Limitations of Health Institutional Decentralization .....	114
5.3 Outstanding Subjects of the Health Institutional Decentralization Process .....	115
<b>Annex: Bibliography .....</b>	<b>116</b>

## Acronyms

<b>AMPE</b>	<b>Asociación de Municipalidades del Perú (Peruvian Municipalities Association)</b>
<b>ANGR</b>	<b>Asamblea Nacional de Gobiernos Regionales (National Assembly of Regional Governments)</b>
<b>BID-PMDE</b>	<b>Banco Interamericano de Desarrollo – Programa de Modernización y Descentralización del Estado (Inter-American Development Bank – Modernization and Decentralization of the State in Peru Program)</b>
<b>CAP</b>	<b>Cuadro de Asignación de Personal (Personnel Assignment Chart)</b>
<b>CIAS</b>	<b>Interministerial Commission on Social Affairs</b>
<b>CIGS</b>	<b>Comisión Intergubernamental de Salud (Intergovernmental Health Commission)</b>
<b>CLAS</b>	<b>Comité Local de Administración en Salud (Local Health Management Committee)</b>
<b>CND</b>	<b>Consejo Nacional de Descentralización (National Council for Decentralization)</b>
<b>CPLAN</b>	<b>Centro de Planificación Nacional (National Planning Center)</b>
<b>CTAR</b>	<b>Consejo Transitorio de Administración Regional (Transitory Council of Regional Administration)</b>
<b>DEAIS</b>	<b>Dirección Ejecutiva de Atención Integral (MOH Executive Directorate for Comprehensive Health Care)</b>
<b>DESS</b>	<b>Dirección Ejecutiva de Servicios de Salud (MOH Executive Department for Health Services Management)</b>
<b>DGSP</b>	<b>Dirección General de Salud de las Personas (General Directorate for Persons-Focused Health Care)</b>
<b>DIGESA</b>	<b>Dirección General de Saneamiento (General Directorate of Environmental Health)</b>
<b>DIRESA</b>	<b>Dirección Regional de Salud (Regional Health Directorate)</b>
<b>DISA</b>	<b>Dirección de Salud (Health Directorate)</b>
<b>DS</b>	<b>Decreto Supremo (Supreme Decree)</b>
<b>ENSAP</b>	<b>Escuela Nacional de Salud Pública (National School of Public Health)</b>
<b>GERESA</b>	<b>Gerencia Regional de Salud (Regional Health Manager's Office)</b>

<b>GR</b>	<b>Gobierno Regional (Regional Government)</b>
<b>GTZ</b>	<b>Agencia Alemana de Cooperación Técnica (German Technical Cooperation)</b>
<b>HTA</b>	<b>Hipertensión Arterial (Arterial Hypertension)</b>
<b>INS</b>	<b>Instituto Nacional de Salud (National Institute of Health)</b>
<b>LOGR</b>	<b>Ley Orgánica de Gobiernos Regionales (Organic Law of Regional Governments)</b>
<b>LOF</b>	<b>Ley de Organización y Funciones (Organization and Functions Law)</b>
<b>LOPE</b>	<b>Ley Orgánica del Poder Ejecutivo (Executive Power Organic Law)</b>
<b>MCC</b>	<b>Mapa Concertado de Competencias (Concerted Map of Health Competencies)</b>
<b>MEF</b>	<b>Ministerio de Economía y Finanzas (Ministry of Economy and Finance)</b>
<b>MINSA</b>	<b>Ministerio de Salud (Ministry of Health)</b>
<b>MIPRE</b>	<b>Ministerio de la Presidencia (Ministry of the Presidency)</b>
<b>MOF</b>	<b>Manual de Organización y Funciones (Organization and Functions Manual)</b>
<b>OD</b>	<b>Oficina de Descentralización (Decentralization Office)</b>
<b>OFICE</b>	<b>Oficina General de Cooperación Externa (General Office of External Cooperation)</b>
<b>OGE</b>	<b>Oficina General de Epidemiología (General Office of Epidemiology)</b>
<b>OGEI</b>	<b>Oficina General de Estadística e Informática (General Office of Statistics and Informatics)</b>
<b>OGP</b>	<b>Oficina General de Planeamiento (General Office of Planning)</b>

<b>OPD</b>	<b>Organismo Público Descentralizado (Decentralized Public Organism)</b>
<b>OPS</b>	<b>Organización Panamericana de Salud (Pan American Health Organization)</b>
<b>OR</b>	<b>Ordenanza Regional (Regional Ordinance)</b>
<b>PAC</b>	<b>Programa de Administración Compartida (Shared-Administration Program)</b>
<b>PAAG</b>	<b>Programa de Administración de Acuerdos de Gestión (Program for the Administration of Management Agreements)</b>
<b>PAP</b>	<b>Presupuesto Analítico de Personal (Analytical Personnel Budget)</b>
<b>PLANSALUD</b>	<b>Plan Sectorial Concertado y Descentralizado para el Desarrollo de Capacidades en Salud (Agreed Sectorial and Decentralized Plan for Health Capacity Building)</b>
<b>PLATAFORMA</b>	<b>Comisión Multisectorial para el Desarrollo de Capacidades en Gestión Pública de los Gobiernos Regionales y Locales (Local and Regional Government Multi-Sector Commission for Capacity-Building in Public Management)</b>
<b>PRODER</b>	<b>Programa de Descentralización y Reforma del Estado de la República del Perú (Peruvian State-Reform and Decentralization Program)</b>
<b>PSBPT</b>	<b>Programa de Salud Básica Para Todos (Program of Basic Health-for-All)</b>
<b>PCM</b>	<b>Presidencia del Consejo de Ministros (Presidency of the Council of Ministers)</b>
<b>REMURPE</b>	<b>Red de Municipalidades Urbanas y Rurales del Perú (Urban and Rural Municipal Network of Peru)</b>
<b>RER</b>	<b>Resolución Ejecutiva Regional (Regional Executive Resolution)</b>
<b>RM</b>	<b>Resolución Ministerial (Ministerial Resolution)</b>
<b>ROF</b>	<b>Reglamento de Organización y Funciones (Organization and Functions By-law)</b>

<b>RSD</b>	<b>Resolución de Secretaría de Descentralización (Decentralization Secretariat Resolution)</b>
<b>SBS</b>	<b>Superintendencia de Banca y Seguros (Superintendency of Banking and Insurance)</b>
<b>SD</b>	<b>Secretaría de Descentralización (Decentralization Secretariat)</b>
<b>SEG</b>	<b>Seguro Escolar Gratuito (Free School Insurance)</b>
<b>SGP</b>	<b>Secretaría de Gestión Pública (Secretariat of Public Management)</b>
<b>SOAT</b>	<b>Seguro Obligatorio para Accidentes de Tránsito (Mandatory Insurance for Traffic Accidents)</b>
<b>TUPA</b>	<b>Texto Único de Procedimientos Administrativos (Charts of Administrative Procedures)</b>
<b>USAID</b>	<b>United States Agency for International Development</b>
<b>USAID HS 20/20</b>	<b>United States Agency for International Development / Health System 20/20</b>
<b>UBASS</b>	<b>Unidad Básica de Servicios de Salud (Basic Health Care Unit)</b>
<b>UTES</b>	<b>Unidad Territorial de Salud (Territorial Health Unit)</b>
<b>ZONADIS</b>	<b>Zonas de Desarrollo Integral de la Salud (Zones of Integral Health Development)</b>

## RESUMEN EJECUTIVO

El presente documento tiene como objetivos realizar: a) Un balance del proceso de descentralización en salud, enfocándose en sus efectos en la institucionalidad en salud durante el período 2002 y 2011, identificando los principales hitos y factores que influyeron en su desarrollo; b) Formular las recomendaciones técnicas para la agenda de descentralización en salud para el mediano plazo (2011 – 2016). Esta propuesta técnica pretende ser un insumo para promover un debate político entre los actores sectoriales con respecto al rumbo del proceso de descentralización en salud. Varios autores señalan la necesidad de repensar el diseño general del proceso de descentralización peruano, en este sentido es indispensable la construcción de una nueva agenda de descentralización en salud para el mediano plazo, la cual debe sustentarse sobre la base de un diálogo técnico sobre las posibles prioridades sectoriales de descentralización en salud.

El segundo capítulo desarrolla el marco de la descentralización en salud, detallando sus antecedentes y la situación en el sector salud previa al proceso de descentralización, tanto en el MINSA como en las regiones. Además, desarrolla el marco conceptual y analítico de la descentralización institucional utilizado en el documento, precisando los componentes necesarios para una efectiva descentralización institucional, además del marco normativo correspondiente al reordenamiento institucional.

Mientras, que el tercer capítulo describe los procesos de transferencia de responsabilidades en salud durante el período 2002 a 2011, comprendiendo tanto lo avanzado en la delimitación de competencias de salud como en la transferencia de competencias y funciones, identificando los avances y limitaciones de dichos procesos. Por su parte, el cuarto capítulo detalla los procesos de adecuación institucional del sector salud en los gobiernos regionales, abarcando tanto los procesos de adecuación organizacional del sector salud, distinguiendo lo acontecido en su ubicación organizacional al interior del Gobierno Regional como lo ocurrido en las propias direcciones o gerencias regionales de salud y sus redes de salud, así como los procesos de desarrollo de capacidades institucionales realizados.

Finalmente, el quinto capítulo señala las conclusiones del balance de la descentralización institucional de salud, distinguiendo sus resultados y limitaciones e identificando los principales temas pendientes. Los resultados encontrados evidencian un insuficiente desempeño gubernamental de los gobiernos regionales en salud debido a las múltiples limitaciones del proceso de descentralización en salud, a pesar de constituir uno de los sectores que ha mostrado mayores avances.

En términos generales, el proceso de descentralización ha estado circunscrito a la transferencia de funciones, con un traspaso parcial de recursos económicos, pero sin la correspondiente adecuación normativa sectorial y carente de la transferencia o el desarrollo de los instrumentos operativos necesarios. Por otro lado, esta transferencia se ha dado sin la adecuada delimitación de competencias y funciones entre los tres niveles de gobierno, careciéndose hasta la actualidad de la identificación precisa de las funciones nacionales y locales. Asimismo, se observa pocas modificaciones en las adecuaciones organizacionales de los tres niveles de gobierno al proceso de descentralización, especialmente de los niveles nacional y local, mientras que en los gobiernos regionales los avances son insuficientes e incipientes para

afrentar los retos de asumir cabalmente su rol de entidad gubernamental. En el MINSA no se ha producido la adecuación a sus nuevos roles y funciones, producto de la transferencia de varias de sus funciones previas a los gobiernos regionales, y más bien se ha profundizado su frondosa y fragmentada estructura organizacional. Finalmente, el balance del proceso de fortalecimiento de capacidades institucionales evidencia limitaciones muy importantes, con el desarrollo de muy escasas acciones y centradas exclusivamente en procesos de capacitación.

## EXECUTIVE SUMMARY

This report is aimed to: a) elaborate a balance of the health decentralization process, focusing on its effects in the governmental institutional arrangements of the health sector during the period between 2002 and 2011, identifying the main milestones and factors that have determined its development; b) formulate technical recommendations for the middle-term decentralization agenda (2011 – 2016). This technical proposal pretends to contribute to the political debate amongst the sector actors about the course of the health decentralization. Several authors mention the obligation to revise the general design of the Peruvian decentralization process, thus it is crucial to build a new health decentralization agenda for the middle –term, which should be done on the basis of a technical consensus about the possible sector priorities on health decentralization.

The second chapter explains the framework of the health decentralization, describing its backgrounds and the health sector situation previous to the decentralization process, both at MOH as in the regions. Additionally, it develops the conceptual and analytical framework for the institutional decentralization used in this report, specifying the required components for achieving an effective institutional decentralization, and also the correspondent legal framework for the institutional rearrangement.

On the other hand, the third chapter describes the transference process of health responsibilities during the period between 2002 and 2011, including the advances both in the delimitation and in the transference of health competencies and functions, and identifying their correspondent achievements and limitations. The fourth chapter clarifies the institutional arrangements of the health sector as a part of the Regional Government, covering their reorganization processes, distinguishing the processes occurred at the Regional Health Directorate's headquarter from those at the Health Networks, as well as the strengthening of institutional capacities.

Finally, the last chapter contains the conclusions of the balance on health institutional decentralization, including its results and limitations, and identifying the main pending issues. The found results show a limited health performance of the Regional Governments, explained by the multiple limitations of the health decentralization process, despite of being the sector which can show important advances in comparison with others.

As a whole, the decentralization process has been constrained to the functions transference, with a partial transference of economic resources, but without the sector laws and regulations up-dating, and with the lack of the development or transference of required operative tools. By other hand, this devolution has occurred without a clear delimitation of competencies and functions amongst the three governmental levels; until now, there is no identification of the national and local functions. Likewise, there are few organizational changes of the three governmental levels, especially at the national and local levels, while the advances in the Regional Governments are insufficient and incipient to tackle the challenges of perform completely their governmental role. At the MOH, there is not any adaptation to its new roles and functions; inclusively, its fragmented organizational structure has overgrowth. Finally, the balance of the institutional capacities strengthening shows important limitations, with the development of few actions and focused exclusively in training processes.

# 1. Introduction

## 1.1 Objectives of this Report

This technical report is aimed to:

- Elaborate a balance of the health decentralization process, focusing on its effects in the governmental institutional arrangements relative to the health sector during the period between 2002 and 2011. The last government period between 2006 and 2011 will be given special emphasis to identify the main milestones and factors that have influenced its development.
- Formulate technical recommendations for the middle-term health decentralization agenda (2011 – 2016).

This technical proposal will serve as an instrument towards the promotion of a political debate amongst the sector actors regarding the course of the health decentralization process. Several authors have stated the need to revise the general design of the Peruvian decentralization process. Furthermore, it is vital to revise the local sectors' decentralization strategy as well as the one directed towards building the sectors' rectory in the framework of the decentralization process. To this end, it is essential to prepare a new health decentralization agenda for the middle-term, which should be supported on the basis of a technical consensus concerning possible priorities in the health sector decentralization.

## 2. Health Decentralization Framework

### 2.1 Health Decentralization Background

In the health sector, decentralization has also constituted a policy guideline that has constantly been reiterated since the eighties. Thus, the health sector in Peru has a long administrative de-concentration experience. Already in 1981, the health sector's organization law<sup>1</sup> established the existence of Regional Health Departments with duties of health programming, personnel administration, financial and material resources; however, they were established as bureaucratic instances due to lack of delegation of authority.<sup>2</sup> As a result, in April, 1981 the Ministry of Health (MINSA) was reorganized towards distinguishing functions and achieving administrative de-concentration and technical-normative centralization.<sup>3</sup> Likewise, in the 1985 health policy guidelines, effective health services decentralization was proposed, with delegation of authority and responsibility up to the health facilities at the local level.<sup>4</sup> However, these initiatives were limited since real health decentralization should be necessarily framed within State-policy-decentralization processes<sup>5</sup>. Due to the disperse nature of health services, decentralization becomes imperative in health management in the search for efficiency. However, when representing an exclusively sector initiative, it is restricted to a mere administrative de-concentration, significantly limiting the possibilities of an inter-sector action, since each sector may also establish its own territorial boundaries due to its interests<sup>6</sup>. This dilemma will always be present among health sector authorities.

Nevertheless, major progress in sector decentralization occurred during the regionalization process that started in 1987 with the promulgation of the *Law of Bases for Regionalization*<sup>7</sup> and the subsequent regional constitution through the corresponding *Organic Law of Regional Governments*, authorizing the establishment of the twelve regional governments since 1990. To accelerate the process, in January, 1990 the Executive Power was granted extraordinary legislative faculties to modify the norms regulating the Executive Power's organization, including ministries and the rest of public institutions<sup>8</sup>. In that context, in February, 1990 the transfer of

---

<sup>1</sup> Poder ejecutivo: *Ley de Organización del Sector Salud, Decreto Legislativo 70*. Lima, abril 1981.

<sup>2</sup> Ewig, Christina: *The Politics of Health Sector Reform in Peru*. Woodrow Wilson Center Workshops on the Politics of Education and Health Reforms. Washington D.C., April 18-19, 2002.

<sup>3</sup> Brito, P.: *Salud, Nutrición y Población en el Perú*. En: *Población y Políticas de Desarrollo en el Perú*. Instituto Andino de Estudios en Población y Desarrollo. Lima, 1983.

<sup>4</sup> Ministerio de Salud: *Lineamientos de política de salud*. Lima, 1985.

<sup>5</sup> Ugarte, Oscar: *Descentralización en salud*. En: *Políticas de salud 2001 – 2006*. Consorcio de Investigación Económica y Social. Lima, julio del 2001.

<sup>6</sup> Palma, E.; Ruffián, D.: *La desconcentración administrativa y las prestaciones sociales*. Instituto Latino Americano y del Caribe de Planificación Económica y Social. Santiago de Chile, 1993.

<sup>7</sup> Congreso de la República: *Ley de Bases de la Regionalización; Ley N° 24650*. Lima, 19 de marzo de 1987.

<sup>8</sup> Távara, Gerardo y Márquez, Jaime: *Sistematización del proceso de descentralización del sector salud*. Promoviendo alianzas y estrategias, Abt Associates Inc. Lima, marzo de 2009

duties, personnel and several resources to the regional governments were approved.<sup>9</sup> Likewise, in March, 1990 the *Executive Power Law*<sup>10</sup> was promulgated, and it established the competencies and organization of the executive power and ordered the transfer of special projects, decentralized public institutions and state-owned companies to the regional governments in addition to the duties and resources expressly numbered in the creation of their organic laws and in the Law of Bases for Regionalization. Likewise, it mandated the adaptation to the decentralized framework of the laws of organization and functions of all of its ministries. The Ministry of Health (MINSA) was assigned the duties to formulate, supervise and evaluate national health policies as well as to rule the activities of health promotion, protection, recovery and rehabilitation, being assigned the administration of class 4 national hospitals.

In this framework, in April, 1990 the *Organization and Functions Law of the Ministry of Health*<sup>11</sup> was promulgated, setting forth the transfer of personnel, infrastructure, material and financial resources, equipment, machinery and the legacy of health services documents to regional governments (with the exception of Lima and Callao, upon installation of the corresponding regional government), as well as health programs and projects. This provided MINSA with a normative and coordination role on health planning. This consolidates the constitution of Regional Health Directorates, which depend on the Regional Secretariat for Social Affairs from regional governments. Furthermore, the National Coordinating Technical Committee, presided by the Ministry of Health and constituted by the Regional Secretariats for Social Affairs and regional health authorities, is created to coordinate and agree on plans, programs and sector budgets.

This process was slowed down between 1990 and 1991 by the government of former president Alberto Fujimori, through urgent decrees oriented towards stopping transfer processes. A good portion of these decrees were derogated by Congress. This worsened tensions between Congress, the executive power and regional governments who claimed the pending transfers. It is worth noting that every former regional government belonged to coalitions or opposite political parties. Thus, Supreme Decree No. 004-91-PCM was approved, therein declaring every central government public entity, regional governments, decentralized public institution, departmental development corporation and special projects under a reorganizational status. While on February 8, 1991, Supreme Decree No. 041-91-PCM was approved, therein restructuring the transfer process to regional governments which should program themselves through agreements between the central government and regional governments, and leaving on hold everything that was done prior to the decree approval while a new legal framework was established for regionalization.<sup>12</sup> With the April 5, 1992 auto coup, the process reverted completely, determining that regional government's regional directorates, including health, would depend on the Transitory Councils of Regional Administration (CTAR) in the departmental realm, which depended on the Ministry of the Presidency (MIPRE) and with officials assigned by this institution.

---

<sup>9</sup> Presidencia del Consejo de Ministros: *Decreto Supremo N° 012-I-90-PCM, aprobó la directiva de transferencia de funciones, personal y diversos recursos a los gobiernos regionales*. Lima, 1990.

<sup>10</sup> Poder ejecutivo: *Ley del Poder Ejecutivo; Decreto Legislativo N° 560*. Lima, 28 de marzo de 1990.

<sup>11</sup> Poder ejecutivo: *Ley de Organización y Funciones del Ministerio de Salud, Decreto Legislativo N° 584*. Lima, 18 de abril de 1990

<sup>12</sup> Távara, Gerardo y Márquez, Jaime: Op. cit.

In the health sector, the implementation of the new Ministry of Health's (MINSA) organizational design was stopped, to the extent that there would be no promulgation of the By-law of its Organization and Functions Law, even though the agreed deadline was due. However, physical assets, human resources and regional health directorates' budgets were not sent back to MINSA but to MIPRE. Nevertheless, in the sector framework this dependency implied a significant degree of administrative de-concentration of health services with regard to MINSA, which maintained however its normative-technical hierarchy and significant levels of administrative and policy influence on health directorates. As a complementary action, that same year the Ministry of Health's Organization and Functions By-law<sup>13</sup> was approved, which established that the main health competencies would be held by MINSA, thus, retaining control on health programs and creating the Health Programs' Executive Management, which had the responsibility of formulating, regulating, supervising and spreading norms, procedures and other national reference devices on health programs and services. Nevertheless, the By-law had some de-concentration logic, to the extent that it was ruled by Decree law No. 584. That is the reason why in this By-law it was also established that Sub-regional Health Directorates were de-concentrated organs in charge of executing the rulings issued by central government technical-administrative institutions, which regulate, supervise, control and promote the development of health activities. Likewise, said By-law established the Zones of Integral Health Development (ZONADIS) as the primary level of the National Health System's organization, constituted with the purpose of providing an integral health care in geo-social spaces previously defined, with a minimum operative unit of administrative character<sup>14</sup>.

In May, 1994, during the ministerial management of Dr. Jaime Freundt, decentralizing initiatives were replaced by a co-management model of isolated health facilities, without dictating any norm that would put an end to ZONADIS. Thus, Supreme Decree No. 01-94-SA<sup>15</sup> was promulgated, where Local Health Management Committees (CLAS) were constituted and the conduction of the Shared-Administration Program (PAC) was declared of national interest and of public need in the health care facilities of primary attention, mainly in critical poverty areas. CLAS was designed as a co-management mechanism with the community; however, it had a procedure that was not democratic enough for selecting the representatives of the community involved. Approximately 35% of first-level health facilities turned out to be administered through this modality. Regarding PAC, this served as a model that opted for a centralized management by delegating some of the organization and function roles to health directorates, for which permanent PAC support teams were constituted in each regional directorate.

Drawing a balance through the whole 90s decade at MINSA and taking into consideration the inconclusive implant of the organizational design of its Organic Law No. 584 from 1990, along with the lack of action in this field during most of the decade, generated a significant organizational state of confusion, which featured the lack of conduction within MINSA, duplicity and intrusion of functions from the different instances, inaction and abandonment of critical

---

<sup>13</sup> Poder ejecutivo: *Reglamento de organización y funciones del Ministerio de Salud; Decreto Supremo N° 002-92-SA*. Lima 20 de agosto de 1992.

<sup>14</sup> *Ibíd.* Artículo 106.

<sup>15</sup> Poder Ejecutivo: *Directiva Base N° 01-94-SA/DM que norma la marcha y desarrollo del Programa de Administración Compartida de los establecimientos de salud del nivel básico de atención; Decreto Supremo N° 01-94 SA*. Lima, 2 de mayo de 1994.

public health functions in the country and absence of sector leadership. For example, several support or consultancy organizational branches (OGEI, OGE, OGP, OFICE), some projects (PAAG, PAC, PSBPT and SEG) as well as institutes (INS, ENSAP) had assumed normative and coordination functions which were of responsibility to line organizations (DIGESA and DGSP) according to the organic law, which restricted the real capacities of the latter organizations.<sup>16</sup> On the other hand, the management model of vertical health programs, with centralized regulation, strategy design and operation as well as supervision, was predominant and was replicated by some MINSA organisms (OGE and INS) in addition to the above-quoted projects. MINSA's organization did not adequate itself to the demands to comply with its duties with regard to population health. This resulted from its centralism and lack of response to regional and local heterogeneous needs as well as the fragmentation and action duplicity, which was more notorious in the existence of multiple vertical health programs<sup>17</sup>:

- Each health program had its own functioning logic without melding with the rest, generating duplicity in the training, monitoring, evaluation, information production and logistic activities as well as in its own interventions. Its management models were centralized, converting the regional and local levels in transmitters or conductors of central management.
- Operations management and logistics handling directly conducted from the central level, overcharging this level's work in duties that were not its responsibility and slowing down the operational level.
- All of that generated a particular organic structure per program that crossed every MINSA level and worsened the existing organic fragmentation in the productive capacity and institutional systems. In this context, inadequate health interventions to regional aspects and local population's idiosyncrasy were performed, hampering the initiative and the operator's commitment.

## 2.2 Start-Up Situation in the Health Sector

The decentralization situation suffered a significant turn in November, 2000 with the falling of Alberto Fujimori's government and the constitution of the new transitional government. At this stage, adequate conditions to start the current decentralization process were created in the framework of democratic transition and certain State-modernization initiatives.

### 2.2.1 Situation within the Ministry of Health

At the beginning of the Transitional Government, MINSA's situation would be characterize by a significant organizational state of confusion with weak internal administration due to the inconclusive implantation of the organizational design of its organic law No. 584 from 1990 and the inaction in this sector during most of the decade. As a result, there would be role duplicity and intrusion of functions from the different organizational branches, inaction and abandonment

<sup>16</sup> Bardález, Carlos: *Avances en la reestructuración y modernización del MINSA*. En: Gaillour, A. y col: Línea de base de la reforma y modernización del sector salud de Perú y su aplicación en el ámbito de intervención del proyecto AMARES. Lima, 2003.

<sup>17</sup> Bardález, Carlos: *Avances en la formulación de un marco legal de descentralización de redes y servicios*. En: Gaillour, A. y col: Línea de base de la reforma y modernización del sector salud de Perú y su aplicación en el ámbito de intervención del proyecto AMARES. Lima, 2003.

of critical public health functions in the country and absence of sector leadership. For example, several support or consultancy organizational branches (OGEI, OGE, OGP, OFICE), some projects (PAAG, PAC, PSBPT and SEG) as well as institutes (INS, ENSAP) had assumed normative and coordination functions which were of responsibility to line organizations (DIGESA and DGSP) according to the organic law, which restricted the real capacities of the latter organizations.<sup>18</sup> On the other hand, the management model of vertical health programs, with centralized regulation, strategy design and operation as well as centralized supervision, was predominant and was replicated by some MINSA organisms (OGE and INS) in addition to the above-quoted projects.

This scenario was favorable for MINSA to start a substantial change process in its most important general directorate, the General Directorate of Persons-Focused Health (DGSP), which had been in the planning stages since 1998. This initiative was oriented towards the integration of the vertical programs in an administrative de-concentration model of health care services, looking to solve these programs' problems of duplicity activities, their inefficacy to achieve health results and these programs' state of confusion and the sector's organizational compartmentalization as a result of these programs' organizational models. This initiative was also being promoted by the World Bank and the Ministry of Economy and Finance since 1998, which had concerns regarding expenses duplicity and inefficiency of the health care programs. In November of this year, a World Bank's assessment mission on the progresses of the MINSA's Supportive Reform Program agreed with MINSA that a reordering and restructuring of MINSA's headquarters should be taken into consideration, mainly directed to modernizing the health care programs and strengthening epidemiology surveillance roles<sup>19</sup>. These agreements were consigned in the commitment matrix for a structural adjustment loan with the goal of the infants and mothers program reorganization for the first semester of 1999<sup>20</sup>. In this scenario, between November 1999 and February, 2000, the DGSP formulated a set of proposals for its reorganization<sup>21, 22, 23</sup>. However, the process lost the necessary political support to be conducted since the executive power focused its attention in the president's re-election campaign and suspended the structural adjustment loan negotiations with the World Bank. Nevertheless, the DGSP continued developing its proposal through the conduction of an institutional development

---

<sup>18</sup> Bardález, Carlos: *Avances en la reestructuración y modernización del MINSA*. En: Gaillour, A. y col: Línea de base de la reforma y modernización del sector salud de Perú y su aplicación en el ámbito de intervención del proyecto AMARES. Lima, 2003.

<sup>19</sup> Banco Mundial / Ministerio de Salud / Ministerio de Economía y Finanzas: *Ayuda memoria de la misión de evaluación del Proyecto de apoyo a la modernización del sector salud en el Perú*. Lima, noviembre de 1998.

<sup>20</sup> Ministerio de Salud / Unidad Coordinadora de la Modernización del Subsector Público: *Listado de compromisos SAL – HEALTH*. Lima, febrero de 1999.

<sup>21</sup> Ministerio de Salud / Dirección General de Salud de las Personas: *Reforma de la Dirección General de Salud de las Personas; nuevo diseño organizacional y nuevas funciones*. Documento de trabajo. Lima, abril de 1999.

<sup>22</sup> Ministerio de Salud / Dirección General de Salud de las Personas: *Plan de Implementación de la Reforma de la Dirección General de Salud de las Personas*. Documento de trabajo. Lima, abril de 1999.

<sup>23</sup> Ministerio de Salud / Dirección General de Salud de las Personas: *Plan de Implementación del Programa Mujer, Niño y Adolescente*. Lima, junio de 1999.

plan<sup>24</sup> aimed at restructuring, at implanting comprehensive health care, administrative de-concentration in health networks and at the concomitant functioning of an Infants and Mothers Insurance that would finance medical care of poor population. Within this plan's framework, norms, methodology and instruments were formulated for implanting the comprehensive health care model and systematizing the experiences developed up until then. However, in spite of the great effort displayed, these initiatives did not have the political support from MINSA executives and thus the process was halted until the transitional government took office.

With the government change, the new transitional government reinitiated negotiations with the World Bank regarding the structural adjustment loan, agreeing once again to the DGSP restructuring commitment to be conducted in February 2001. With this demand, the new Ministry of Health management officials, headed by Dr. Eduardo Prettel (11/23/2000 – 07/28/2001), retook the political decision of DGSP restructuring. Thus, MINSA sanctions the 1<sup>st</sup> modification of the Organization and Functions By-laws from this general directorate in March, 2001<sup>25</sup>, which was not implemented<sup>26</sup>, as well as a definite modification in June, 2001<sup>27</sup>. With this guarantee, at the beginning of July, 2001, the DGSP issued the ruling documents it had been working on and started institutional arrangements for its reorganization, which consisted on the transfer of the documentation, human resources and assets to new created structures. Within this incipient implementation process scenario, the change of government took place in July 28, 2011.<sup>28</sup>

The new ministerial management, directed by Dr. Luís Solari, maintained the organizational structure received from the DGSP, directing its action towards health program's integration and towards the consolidation of new executive departments, although it did not develop a systematic organizational process that includes management process adaptation to the new organizational design and formulation of the corresponding management documents (organization and functions manual, personnel assignment chart and operations manual).

However, in January, 2002, the Congress of the Republic promulgated a new MINSA<sup>29</sup> organic law, due to the new ministerial management initiative, with which a MINSA's organic restructuring process was initiated. This new law was elaborated in August and September, 2001 within MINSA; then, it was revised by CIAS and subsequently by the Council of Ministries to be finally sent to Congress. The PCM and the Ministry of Economy and Finance had questioned the elaboration of a new organic law without having defined the executive power

---

<sup>24</sup> Ministerio de Salud / Dirección General de Salud de las Personas: *Plan de desarrollo institucional de la DGSP*. Documento de trabajo. Lima, agosto del 2000.

<sup>25</sup> Ministerio de Salud: *Resolución Ministerial N° 163-2001-SA/DM, modificando artículos del Reglamento de Organización y Funciones del Ministerio de Salud*. Lima, 14 de marzo del 2001.

<sup>26</sup> Bardález, C.: *Sistematización de los modelos de gestión de recursos humanos en redes básicas de servicios de salud. Informe de consultoría*. Organización Panamericana de la Salud. Lima, julio del 2002.

<sup>27</sup> Ministerio de Salud: *Resolución Ministerial N° 343-2001-SA/DM, modificando la Resolución Ministerial N° 163-2001-SA/DM que modificó el Reglamento de Organización y Funciones del Ministerio de Salud*. Lima, 19 de junio del 2001.

<sup>28</sup> Bardález, Carlos: *Avances en la reestructuración y modernización del MINSA*. Lima, 2003. Op. cit.

<sup>29</sup> Congreso de la República: *Ley N° 27657; Ley del Ministerio de Salud*. Lima, 29 de enero del 2002.

(Executive Power Law) and decentralization (Decentralization Bases Law) framework. Nonetheless, said law was finally promulgated by Congress with very few modifications, while the Decentralization Bases Law was just promulgated in July, 2002<sup>30</sup>, with which it was evident that there were significant inconsistencies.<sup>31</sup> Overall, the organization established in the new law shows a centralized bias<sup>32</sup>, which is a step backwards with regard to the previous law. Furthermore, it essentially maintains the same organizational architecture, although a bit broader since it creates several organic units<sup>33</sup>. For the new organization implementation, two regulations were promulgated in November, 2002: The By-law on MINSA's law<sup>34</sup> as well as MINSA's Organization and Functions By-law<sup>35</sup>.

In the programming aspect, this ministerial management included within its policy guidelines<sup>36</sup> the development of health networks and the development of a new comprehensive health care model. To this end, the DGSP incorporated the "regulation for operation, organization, network, micro-network and MINSA's health centers management" in its 2002 – 2006<sup>37</sup> strategic plan as line of action, as well as "program development for people per life stages, family integral care, public and community health and healthy environments," detailing the following activities: <sup>38, 39</sup>

- Health networks organization and operation.
- Strengthening of network resolution capacity (equipment and infrastructure.).
- Regulation of the operation of health care centers.
- Development of health care programs per life stages.
- Development of national public health care programs.

---

<sup>30</sup> Congreso de la República: *Ley de bases de la descentralización*; Ley N° 27783. Lima, 17 de julio del 2002.

<sup>31</sup> Bardález, Carlos: *Avances en la reestructuración y modernización del MINSA*. Op. cit.

<sup>32</sup> The law assigns the ministry the power to establish health regional and local governments' competencies and to appoint regional health authorities.

<sup>33</sup> Senior Management Advisory Council, National Defense General Office, General Directorate of Human Resources Management, General Directorate of Health Promotion.

<sup>34</sup> Poder ejecutivo: *Reglamento de la Ley N° 27657 - Ley del Ministerio de Salud*. Decreto Supremo N° 013-2002-SA. Lima, 16 de noviembre de 2002.

<sup>35</sup> Poder ejecutivo: *Reglamento de organización y funciones del Ministerio de Salud*. Decreto Supremo N° 014-2002-SA. Lima, noviembre de 2002.

<sup>36</sup> Ministerio de Salud: *Lineamientos de política sectorial para el período 2002-2012 y principios fundamentales para el quinquenio agosto 2001 – julio 2006*. Lima, diciembre del 2001.

<sup>37</sup> Ministerio de Salud / Dirección General de Salud de las Personas: *Lineamientos estratégicos 2002 – 2006*. Lima, 2002.

<sup>38</sup> Bardález, Carlos: *Avances en el desarrollo de redes de salud*. En: Gaillour, A. y col: Línea de base de la reforma y modernización del sector salud de Perú y su aplicación en el ámbito de intervención del proyecto AMARES. Lima, 2003.

<sup>39</sup> Ministerio de Salud / Dirección General de Salud de las Personas: *Plan operativo 2003*. Lima, 2003.

- Development of the national program for prevention and control of non-transmissible diseases (AHT, diabetes, blindness and neoplasms).

However, these plans had a quite slow start-up apparently because of the difficulty to build on consensus regarding health network design, questioning during several months networks, micro-networks and CLAS<sup>40</sup>. For this reason, only after a year of having taken over the ministerial responsibilities, in July, 2002 MINSA promulgated a guideline<sup>41</sup> so DISAs could delimitate their health networks and micro-networks and make the corresponding formalization, after the approval of its proposals by MINSA. Furthermore, it established a National Registry of Networks and Micro-Networks.<sup>42</sup> DESS suggested that networks become executing units; however, said resolution did not establish any procedure for its administrative and budgetary order but its delimitation.<sup>43</sup> The complexity of implementing both strategic axis required plans for a coherent development of all of its components (health networks, comprehensive health care, DGSP restructuring) in the national scenario, involving every DGSP departments as well as several MINSA's general directorates or offices. Nevertheless, efforts were focused only in DGSP and mainly in DEAIS.

On the other hand, these programmatic weaknesses and limitations in implementing DGSP's organizational changes caused a significant loss in the health performance, leading to its wear out, which in some cases had reached critical levels in tuberculosis and vaccinations which endangered the objectives reached. For example, in the case of tuberculosis there was a significant decrease of the performance program, which led the WHO to conduct an external assessment in February, 2002 that recommended the adoption of emergency measures. A similar situation occurred in August, 2002 with vaccinations, with a report that also showed very disappointing conclusions.<sup>44</sup>

### 2.2.2 Situation in the Regions

When the Transitional Government started office, the 34 Health Directorates depended in an administrative manner on the Transitory Council of Regional Administration (CTAR) of departmental realm, which in turn belonged to the Ministry of the Presidency (MIPRE) and whose official authorities were appointed by it. Nevertheless, in the sector framework, this dependency implied a significant degree of administrative de-concentration of the health care services with regard to MINSA, who maintained its technical-regulatory hierarchy as well as important levels of administrative and political influence over Health Directorates. These health

---

<sup>40</sup> Bardález, C.; Gaillour, A.; Güesmez, Ana: *Evaluación rápida sobre la provisión de los servicios de salud en el Perú*. Informe Final de consultoría. DFID. Lima, septiembre del 2002.

<sup>41</sup> Directiva DGSP –DESS N° 001-05-2002 que fue publicada en el Peruano el 17 de julio como Resolución Ministerial N° 1125-2002-SA/DM.

<sup>42</sup> Ministerio de Salud: *Directiva DGSP –DESS N° 001-05-2002 para la delimitación de Redes y Microrredes de Salud*. Resolución Ministerial N° 1125-2002-SA/DM. Lima, 17 de julio del 2002.

<sup>43</sup> Bardález, Carlos: *Avances en el desarrollo de redes de salud*. Op. cit.

<sup>44</sup> Bardález, Carlos: *Políticas y planes para la definición e implantación del modelo de atención*. En: Gaillour, A. y col: *Línea de base de la reforma y modernización del sector salud de Perú y su aplicación en el ámbito de intervención del proyecto AMARES*. Lima, 2003.

directorates were formed on the basis of health sub-regions and in several cases there was more than one per department.

The Decentralization Bases Law<sup>45</sup> established MIPRE's deactivation through the transference of its central relevant organs to CND as well as its CTAR to the Presidency of the Council of Ministers (PCM). Thus, on August 1, the national government transferred said organs from MIPRE to CND (Supreme Decree No. 018-2002-PRES)<sup>46</sup>, as well as the CTAR were transferred to PCM (Supreme Decree No. 020-2002-PRES)<sup>47</sup>. Regional governments were constituted on January 1, 2003, as established by the Decentralization Bases Law<sup>48</sup>, through the corresponding transference of CTAR from CND. This was done with the signature of assets and liabilities acts by PCM<sup>49</sup> representatives and it was established in the 2003<sup>50</sup> budget law. Subsequently, a complementary transfer of budgetary items was performed on February 20, 2002<sup>51</sup>. It is worth mentioning that in the case of the health sector, such transference comprised the previously-mentioned health directorates (DISA). In compliance with the Decentralization Bases Law, pre-existing sub-regions still maintained their validity, structure and administrative competencies at the time of transfer, being left at the criterion of the new regional governments to consider their continuity at the moment of approval of their internal organization<sup>52</sup>, authorized to be conducted during the first trimester through the 2003<sup>53</sup> public budget law. Finally, no regional government modified DISA's structure.

On the other hand, on January 1, 2003, Law No 27902 was therein approved, thus modifying the Organic Law of Regional Governments and establishing the following: <sup>54</sup>

- Health functions are assigned to the Social Development Management Office.

<sup>45</sup> Congreso de la República: *Ley de bases de la descentralización*. Op. cit. Tercera, cuarta y quinta disposición transitoria.

<sup>46</sup> Poder Ejecutivo: *Transfieren diversos órganos del Ministerio de la Presidencia al Consejo Nacional de Descentralización; decreto supremo N° 018-2002-PRES*. Lima, 1° de agosto de 2002.

<sup>47</sup> Poder Ejecutivo: *Transfieren los Consejos Transitorios de Administración Regional a la Presidencia del Consejo de Ministros; Decreto Supremo N° 020-2002-PRES*. Lima, 1° de agosto de 2002.

<sup>48</sup> Congreso de la República: *Ley de bases de la descentralización*. Op. cit. Primera disposición transitoria.

<sup>49</sup> CND: *Designan representantes de la PCM facultados para realizar la transferencia de activos y pasivos de los CTAR a los gobiernos regionales; Resolución Ministerial N° 485-2002-PCM*. Lima, 28 de diciembre de 2002.

<sup>50</sup> Congreso de la República: *Ley de presupuesto del sector público para el año fiscal 2003; Ley N° 27879*. Lima, 13 de diciembre de 2002.

<sup>51</sup> Poder Ejecutivo: *Autorizan transferencia de partidas en el presupuesto del sector público a favor de pliegos de los gobiernos regionales; Decreto Supremo N° 021-2003-EF*. 20 de febrero de 2002.

<sup>52</sup> Congreso de la República: *Ley de bases de la descentralización*. Op. cit. Sexta disposición transitoria.

<sup>53</sup> Congreso de la República: *Ley de presupuesto del sector público para el año fiscal 2003; Ley N° 27879*. Lima, 13 de diciembre de 2002. Duodécima disposición complementaria.

<sup>54</sup> Congreso de la República: *Ley N° 27902, ley que modifica la Ley Orgánica de los Gobiernos Regionales N° 27687. para regular la participación de los alcaldes provinciales y la sociedad civil en los gobiernos regionales y fortalecer el proceso de descentralización y regionalización*. Lima, 1° de enero del 2003.

- The exclusive competency of the National Government to define, direct, rule and manage national and sector policies, as well as the attribution of regional governments to define, rule, direct and manage their regional policies and the exercise of their general and specific functions, in compliance with national and sector policies.
- Regional sector directors were responsible for the implementation and conduction of the national and regional sector policies in the regional realm, depending on the relevant ministry and Regional Management.
- The appointment of regional sector directors was to be held through a public bid by the regional government in coordination with the national government, through CND-established procedures. As long as this process remained unfinished, the directors in exercise were going to continue on duty under the regional government's administrative dependency and the technical and functional dependency of the relevant ministry.

Regarding the regional directors' screening process, the announcement would have to be done by each regional government in coordination with the central government, needing the establishment of a regional bid commission formed by the regional government's general manager, a representative from the central government's relevant sector and one member from the region's Chamber of Commerce<sup>55</sup>, while MINSA should send a delegate.<sup>56</sup> Taking advantage of this regulation, in many regions MINSA did not assign the relevant delegates, thus postponing the bid and maintaining the directors assigned by the national government at the beginning of its ministerial management<sup>57</sup>. On the other hand, through this regulation, the regional government should evaluate the sector regional director's performance every six months, together with the relevant ministry<sup>58</sup>.

DISA's double dependency created confusion in the regional realms since regional governments did not have precise mechanisms for their technical and functional conduction, even though they had the administrative responsibility over their management. Moreover, the new MINSA law established that DISA Lima and Callao constituted de-concentrated organs<sup>59</sup> while its ruling stated that the MINSA By-law on DISA's organization would also be applied to the DIRESA's that maintained technical and functional dependency with MINSA, as well as with the de-concentrated organs<sup>60</sup>. Likewise, DIRESA's and its de-concentrated organs' technical-normative management documents required the favorable technical opinion from MINSA. Thus, the By-law on MINSA's law established that DISA had health authority because of their

<sup>55</sup> The need to have a representative from the Chamber of Commerce as part of the Regional Bid Commission was subsequently eliminated by means of Presidential Resolution No. 025-CND-P-2003, dated February 27, 2003.

<sup>56</sup> Consejo Nacional de Descentralización: *Lineamientos generales para el concurso público de selección de directores regionales sectoriales*. Resolución presidencial N° 012-CND-P-2003. Lima, 31 de enero del 2003.

<sup>57</sup> Bardález, Carlos: *Avances en la formulación de un marco legal de descentralización de redes y servicios*. Lima, 2003. Op. cit.

<sup>58</sup> Consejo Nacional de Descentralización: Resolución presidencial N° 012-CND-P-2003. Artículo 5.4.

<sup>59</sup> Congreso de la República: *Ley N° 27657; Ley del Ministerio de Salud*. Lima, 29 de enero del 2002. Artículos 6 y 29.

<sup>60</sup> Poder ejecutivo: *Reglamento de la Ley N° 27657 - Ley del Ministerio de Salud*. Decreto Supremo N° 013-2002-SA. Lima, 16 de noviembre de 2002. Artículo 29.

delegation. They should also ensure their jurisdiction's compliance with sector policies, mission, vision, objectives and regulations, as well as to provide assistance, technical and administrative support to the health networks management and hospitals under their dependency. Moreover they should manage to keep public entities and organizations in general informed and ensure their compliance with health regulation.<sup>61</sup>

On the other hand, due to limitations in the programmatic rectory on the part of MINSA, the sense of disorientation was frequently observed in DISA due to an absence of conduction. In general, they used to have the tendency to inadequately replicate the same organizational design of central-level programs when other functions and competencies were to be set in place. Likewise, each DISA interpreted and organized integral care on its own way, in spite of considering an acceptance level regarding the integration of health vertical programs.<sup>62</sup> To that, we should add the organizational state of confusion in the health service management scenario resulting from discontinuing the relevant policies developed by MINSA in the 90's. Thus, sub-regional health directorates, health services networks, health micro-networks, territorial health units (UTES), basic health care units (UBASS), basic health services (SBS), Zones of Integral Health Development (ZONADIS), CLAS, etc. were superimposed on a variety of organizational models. This non-definition of the organizational models generated role function duplicity with a subsequent creation of conflicts among several instances, as well as a lack of function delegation which is required in an autonomous management framework.<sup>63</sup>

Moreover, when the regional governments were already installed and the decentralization process was set forth, MINSA issued a Health Directorate and Health Network Organization and Functions By-law.<sup>64</sup> The purpose of the mentioned By-law was to "establish DISA's standardized organization nationwide, regulating its nature, vision, mission, general strategic and functional objectives as well as the organic structure and functional objectives of its organic units". This meant that "every DISA, nationwide, elaborated its relevant ROF according to the mentioned regulation"<sup>65</sup>. Thus, every DISA holds the same mission or role, as shown in the following box<sup>66</sup>. As observed, it focuses its objectives in protecting personal dignity by promoting health in order to create a health and solidarity culture by preventing disease and guaranteeing integral health care. In other words, an objective that is not relevant to the sector's responsibilities and that states as its essential duties health promotion and health care services provision, leaving aside stewardship functions which were otherwise relevant to health authorities.

---

<sup>61</sup> *Ibídem*. Artículo 24.

<sup>62</sup> Bardález, Carlos: *Políticas y planes para la definición e implantación del modelo de atención*. Op. cit.

<sup>63</sup> Bardález, Carlos: *Avances en el desarrollo de redes de salud*. Op. cit.

<sup>64</sup> Ministerio de Salud: *Aprueban reglamentos de organización y funciones de las direcciones de salud y de las direcciones de red de salud; Resolución Ministerial N° 573-2003-SA/DM*. Lima, 23 de mayo de 2003.

<sup>65</sup> *Ibídem*. Artículo 1.

<sup>66</sup> *Ibídem*. Artículo 7.

**Box No. 1: Mission of Health Directorates (DISA)**

The mission of Health Directorate is to protect personal dignity by promoting health in order to create a health and solidarity culture by preventing disease and ensuring an integrated health care of the entire population; in compliance with national health policy and on the objectives agreed on with all public and private sector entities and other social actors. The individual is the center of our mission to which we dedicate with respect for life and for the fundamental rights of every Peruvian, from the moment of conception until natural death, respecting the natural course of life and contributing to the great national task of achieving the development of all our citizens. Health Sector employees are agents of change in constant improvement, who continuously enhance the quality of our service to obtain the maximum wellbeing of people.

The organic structure established for DISA comprised the same organs as MINSA<sup>67</sup>. The rigidity of the mentioned organizational model and the special design of its structure, compared to MINSA's, should be noted in spite of the evident difference in their roles and functions. This may be attributed as a result of the compartmentalized organizational structure of MINSA, on which each directorate and office maintained vertical hierarchical relationships with its counterpart in the regional realm, independently from its organizational nature and location. As described in the following sections, this fact will be vital for DIRESA to further adapt their organization for exercising the functions passed on to them.

The same ministerial resolution mentioned above<sup>68</sup> also established a standardized organization of the health network nationwide<sup>69</sup>, regulating their nature, vision, mission, general strategic and functional objectives as well as the organic structure and functional objectives of its organic units.<sup>70</sup> The health network's standardized mission is shown in Box No. 2<sup>71</sup>. Likewise, the organizational structure established for health network is shown in Graphic No. 1. This organizational design had a bureaucratic bias, where the health network headquarters was conceived as an exclusively administrative apparatus where its health micro-networks acted as line organizational branches. Thus, the headquarters lacked technical organizational branches responsible for organizing and monitoring micro-networks, as well as for organizing and managing support systems (reference, transportation and communications, lab network, medicine supply, etc.).

**Box No. 2: Mission of the Health Network**

The mission of the Health Network is to ensure that the entire assigned population gains access to quality health care services which manage and provide its resources to address people's health care needs from the moment of conception until natural death, to restore people's health in compliance with the new integrated health structure for disease prevention, health protection and recovery of every person in emergency and disaster situations and to support the communities and institutions in creating healthy environments.

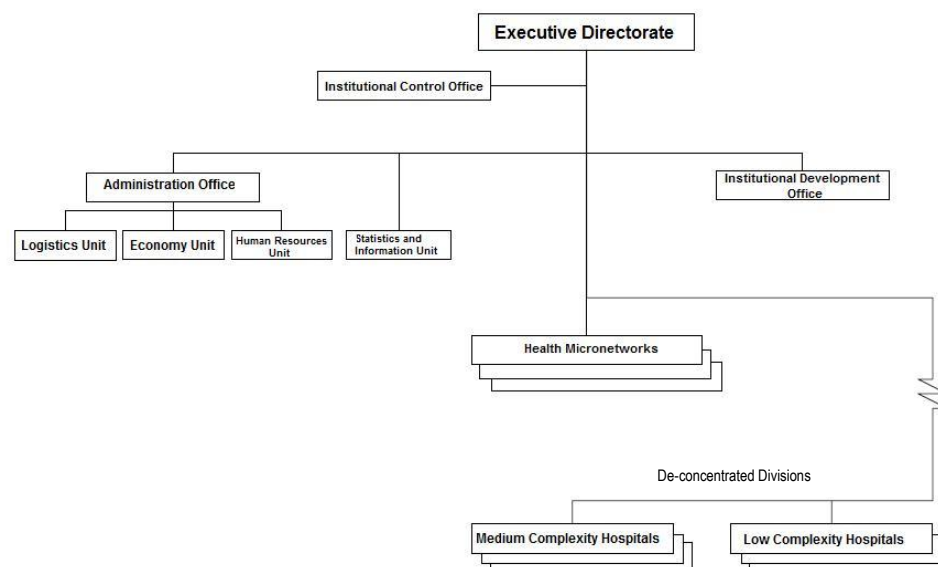
<sup>67</sup> Ibídem. Artículo 10.

<sup>68</sup> Ministerio de Salud: *Aprueban reglamentos de organización y funciones de las direcciones de salud y de las direcciones de red de salud; Resolución Ministerial N° 573-2003-SA/DM*. Lima, 23 de mayo de 2003.

<sup>69</sup> In Article 3, it is therein provided that this regulation inclusively involves public and private sector organizations and the national health care system in their respective geographic and population realms.

<sup>70</sup> Ibídem. Artículo 1 del ROF de redes.

<sup>71</sup> Ibídem. Artículo 6 del ROF de redes.

**Graphic No. 1: 2003 Organic Structure of Health Networks**

The quoted By-law stated that all of the above-mentioned instances (sub-regional health directorates, health networks, UTES, UBASS, SBS or ZONADIS) would be re-assumed and restructured in health network. DISA should manage to prevent and conduct legal and technical actions for the transference of documentation and human, budget, financial and material resources for the new health network.<sup>72</sup> Likewise, once MINSA approved its delimitation by means of a Ministerial Resolution, DISAs should have formulated and sent their relevant ROFs for MINSA's favorable technical opinion and approval by means of the relevant Resolution<sup>73</sup>. Nevertheless, the mentioned By-law did not state the procedures needed to obtain those results and MINSA only developed technical assistance actions for its delimitation and not for its organization. It did not take over coordination actions with MEF for these transferences and administrative arrangements. Thus, after a delimitation process that took almost a year,<sup>74,75</sup> in June, 2003 MINSA approved the delimitation of health networks and micro-networks nationwide through a ministerial resolution, constituting 108 health networks and 712 health micro-networks.<sup>76</sup> As a consequence, there was a weakness at local management levels, as it was find out that health networks which were not simultaneously budget executing units lacked the needed capacities and responsibilities for minimum operation and management autonomy<sup>77</sup>,

<sup>72</sup> *Ibíd.* 1° disposición transitoria del ROF de DISA.

<sup>73</sup> *Ibíd.* 1° disposición transitoria del ROF de redes.

<sup>74</sup> Directiva DGSP –DESS N° 001-05-2002 que fue publicada en el Peruano el 17 de julio como Resolución Ministerial N° 1125-2002-SA/DM.

<sup>75</sup> Ministerio de Salud: *Directiva DGSP –DESS N° 001-05-2002 para la delimitación de Redes y Microrredes de Salud*. Resolución Ministerial N° 1125-2002-SA/DM. Lima, 17 de julio del 2002.

<sup>76</sup> Ministerio de Salud: *Delimitación de las Direcciones de Salud, Direcciones de Red de Salud y Microrredes de Salud del Ministerio de Salud*. Resolución Ministerial 638-2003-SA/DM. Lima, 9 de junio del 2003.

<sup>77</sup> Ugarte, Mayen; Arguedas, Cinthya: *Modelo de descentralización en salud para el nivel local*. Promoviendo alianzas y estrategias, Abt Associates Inc. Lima, 2007.

whereas only a few health micro-networks proved minimum operation to be considered as basic service management. For the rest, micro-networks did not control any management process.

## 2.3 Conceptual and Analytical Framework of the Institutional Decentralization

This section seeks to develop an analytical framework for the study of institutional decentralization and its application to the health sector. First of all, a systemic reference revision on the subject matter allows inferring that there is broad polysemic terminology. Thus, one of the main issues is that different concepts are used for the term *decentralization*,<sup>78,79</sup> becoming meaningless.<sup>80</sup> As a result, clarity and theoretical and methodological strictness become a need in order to obtain an effective description, explanation and fact prediction. Overall, there are two different concepts used for the term decentralization and the greatest issue is that both are confused in the analytical task. This is why it is vital to distinguish between **decentralized State** and **decentralization process**:

- *Decentralized State* is understood as a state's organizational system in which the different governmental levels form a decentralized governmental system, through which the state's power is significantly shared, thus leading to their determined autonomy levels,<sup>81</sup> that is, the authority held by municipalities, provinces, regions or other territorial entities to be governed by their own regulations and governmental bodies. This type of State may be defined as the decentralized government's target image that should be achieved through the transformation of the current governmental system's model in a country and its spatial dimension.<sup>82</sup> In this new system, there must be a democratic and autonomic distribution of power, authority as well as social and state responsibility within the nation's territories, giving back to citizens and their representatives the capacity to decide on their own lives.<sup>83,84</sup>
- The concept of *decentralization process* is in turn the deliberate course of events oriented so a State deals with matters with a determined degree of centralism (initial state) towards other more decentralized (final state),<sup>85</sup> substituting a hierarchical and centralized governance system with other decentralized governance system. It comprises a set of public policies directed to reforming the State through authority, responsibility and resource redistribution among the different governmental levels, in order to modify power balance

<sup>78</sup> Cohen, John; and Peterson, Stephen: *Methodological issues in the analysis of decentralization*.

<sup>79</sup> Guimaraes, Luisa: *Modalidades de descentralización en el sector salud y sus contribuciones a la equidad: elementos fundamentales para la formulación de un marco normativo*. OPS. Serie Informes Técnicos N° 76. Washington DC, septiembre, 2001.

<sup>80</sup> Peckham, S.; Exworthy, M.; Powell, M.; and Greener, I. (2005): *Decentralisation as an organizational model for health care in England*. NCCSDO. London.

<sup>81</sup> Real Academia Española: *Diccionario de la lengua española*. Vigésima segunda edición.

<sup>82</sup> Guimaraes, Luisa: (2001). Op. cit.

<sup>83</sup> Dammert, Manuel (2001): *La democracia territorial, Hacia la refundación nacional descentralista*. Lima.

<sup>84</sup> Brinkerhoff, Derick y Leighton, Charlotte: *Nueva perspectiva para los ejecutores: Descentralización y reforma del sistema de salud*. Partners for Health Reformplus. Septiembre de 2002.

<sup>85</sup> Prud'homme, Remy: *On the dangers of decentralization*. Policy research working paper 1252. The World Bank. Washington D.C., 1994.

among these.<sup>86</sup> This process should be integrally conceptualized, taking into consideration every dimension that may be required, making sense only as long as it forms part of ample state-reform processes, with substantial changes in its institutional structures as well as in governmental functions so as to improve the government's overall performance. These organizational changes may imply redefining these instances' roles and new administrative structures at every governmental level, transforming the existing relationships among governmental levels from a governmental system involving *character subordination* to another involving *coordination and cooperation*.<sup>87</sup> That may imply the need to introduce decentralizing, democratizing, and modernizing public management and State-structure reforms, among others.

In that context, a decentralized State may include the following dimensions; nonetheless, in practice, fiscal, institutional and political aspects are mixed with each other:<sup>88</sup>

- Political decentralization.
- Institutional or administrative decentralization.
- Fiscal Decentralization.

### 2.3.1 Institutional Decentralization Components

In 2002, the current political decentralization process was initiated in Peru, with the approval of the Constitutional Reform, Decentralization Bases Laws and Regional and Local Governments Organic Law, which established the current legal framework (see Table N° 1 which shows the summary of the current legal framework). In this process, the significant role played by the health sector was relevant in regards to the current decentralization reform. Regional governments are created and supported by such legal framework, specifically by its organic law<sup>89</sup> and its modifying law;<sup>90</sup> therein establishing that they are the regional governmental instances in charge of organizing and conducting regional public management with political, economic and administrative autonomy in matters pertaining to their competencies and being part of the budgetary set. Their is to encourage a sustainable integral regional development, promoting public and private investment and employment, as well as guaranteeing the full exercise of the entire population's rights and equality of opportunity according to national, regional and local development programs and plans.

This decentralization process seeks to reach a *decentralized State*, understood as a state's organizational system in which the different governmental levels form a decentralized

---

<sup>86</sup> Falletti, Tulia: *A Sequential Theory of Decentralization: Latin American Cases in Comparative Perspective*. The American Political Science Review, Vol. 99, N° 3 (Aug., 2005): 327-346.

<sup>87</sup> Guimaraes, Luisa (2001): Op. cit.

<sup>88</sup> Lister, S., and Betley, M.: *Approaches to decentralization in developing countries*. Capetown, June, 1999.

<sup>89</sup> Congreso de la República: *Ley orgánica de los gobiernos regionales; Ley N° 27687*. Lima, 16 de noviembre del 2002.

<sup>90</sup> Congreso de la República: *Ley N° 27902, ley que modifica la Ley Orgánica de los Gobiernos Regionales N° 27687. para regular la participación de los alcaldes provinciales y la sociedad civil en los gobiernos regionales y fortalecer el proceso de descentralización y regionalización*. Lima, 1° de enero del 2003.

governmental system, through which the state's power is significantly shared, thus leading to their determined autonomy levels;<sup>91</sup> that is, the authority held by municipalities, provinces, regions or other territorial entities to be governed by their own regulations and governmental bodies. In this new system, there must be a democratic and autonomic distribution of power, authority as well as social and state responsibility within the nation's territories, giving back to citizens and their representatives the capacity to decide on their own lives<sup>92,93</sup>.

It is evident that the mentioned process substantially modifies the public management framework in regional realms by transferring a significant number of sectorial competencies and functions to regional governments and their sector directorates. So that regional governments may put them into effect, it is necessary that the decentralization process comprises a set of public policies directed to reforming the State through authority, responsibility and resource redistribution among the different governmental levels, in order to modify power balance among these.<sup>94</sup> That implies ample state-reform processes, with substantial changes in its institutional structures as well as in governmental functions so as to improve the government's overall performance, redefining these instances' roles and new administrative structures at every governmental level, transforming the existing relationships among governmental levels from a governmental system involving *character subordination* to another involving *coordination and cooperation*<sup>95</sup>. This transition should be guaranteed by a set of basic rules institutionalizing a new power balance among the different governmental levels. These rules require being explicit and reasonably permanent, to the extent of generating a common and stable scenario for the different political actors involved in the process, which would have to prefer their adhesion rather than an estrangement of these. Nonetheless, there will always be a negotiation and variation margin in their interpretation.<sup>96,97</sup> In this sense, the effects of a decentralization process on government institutionalization should be as follows:<sup>98</sup>

- Decentralized governance,<sup>99</sup> interpreted as the intergovernmental political coordination mechanisms for the formulation, conduction and control of national, regional and local public

<sup>91</sup> Real Academia Española: *Diccionario de la lengua española*. Vigésima segunda edición.

<sup>92</sup> Dammert, Manuel (2001): *La democracia territorial, Hacia la refundación nacional descentralista*. Lima.

<sup>93</sup> Brinkerhoff, Derick y Leighton, Charlotte: *Nueva perspectiva para los ejecutores: Descentralización y reforma del sistema de salud*. Partners for Health Reformplus. Septiembre de 2002.

<sup>94</sup> Falletti, Tulia: *A Sequential Theory of Decentralization: Latin American Cases in Comparative Perspective*. The American Political Science Review, Vol. 99, N° 3 (Aug., 2005): 327-346.

<sup>95</sup> Guimaraes, Luisa: *Modalidades de descentralización en el sector salud y sus contribuciones a la equidad: elementos fundamentales para la formulación de un marco normativo*. OPS. Serie Informes Técnicos N° 76. Washington DC, 2001.

<sup>96</sup> World Bank: *Decentralization, rethinking government*. In: World Development Report 1999/ 2000. 2000. Capítulo 5.

<sup>97</sup> Javed, S.; Perry, G.; Dillinger, W.: *Beyond the center; Decentralizing the state*. The World Bank. Washington, D.C., 1999.

<sup>98</sup> *Decentralization; An overview*. En: Sourcebook on Decentralization in Asia.

<sup>99</sup> The United Nations Development Program (UNDP) defines decentralized governance as “the systematic and harmonious interrelationship resulting from the balance of powers and responsibilities among the central

policies in the country,<sup>100</sup> also comprising the governance of each governmental level for its competency policies. Public policy is defined as a set of objectives, decisions and actions conducted by a government to solve issues which in a determined moment citizens and the government itself consider as a priority.<sup>101,102</sup>

- Decentralized management for the sectorial enforcement, defined as exercising governing sector-guiding functions by the different governmental levels to coherently guarantee citizen's rights as recognized by the State, inherent to the individual or related to them as consumers of goods and services. It includes the management<sup>103</sup> of audits operations performed in order to guarantee the compliance of governmental regulation frameworks.
- Decentralized management for the provision of public goods and services, regarding *operations management*, comprising the design and management of every action with a tendency to generate the greatest added value through planning, organization, direction and production control, not only of goods but of public services, destined to guarantee quality, productivity, efficiency and user satisfaction.<sup>104,105</sup> It includes the design of the production function and production units as well as the purchase, development and use of the necessary resources to deliver goods and services.

To achieve this, it is basically required to have at least the following political components:

- Transference of responsibilities.
- Institutional arrangement and strengthening.
- Public management arrangement to public administration systems. Administrative systems<sup>106</sup> refer to the set of principles, rules, techniques and instruments through which public administration activities required to be performed by every or several State entities

---

government and other governmental levels and non-government actors, as well as the capacity of local governments to exercise their decentralized responsibilities by using participative mechanisms.”.

<sup>100</sup> *Decentralization; An overview*. En: *Sourcebook on Decentralization in Asia*.

<sup>101</sup> Tamayo, Manuel. 1997. *El análisis de las políticas públicas*. En: “La nueva administración pública”, compilado por Rafael Bañón y Ernesto Carrillo, 281-311. Madrid: Alianza Universidad.

<sup>102</sup> Jaramillo, Martha: *La descentralización: una mirada desde las políticas públicas y las relaciones intergubernamentales en Baja California*. El Colegio de Sonora; Sonora, México. Región y Sociedad, Vol. XXII, núm. 49, 2010, pp. 177-200.

<sup>103</sup> The term, *operations management* of an organization refers to all of those activities directly related with the compliance of its essential purpose.

<sup>104</sup> <http://www.monografias.com/trabajos20/administracion-operaciones/administracion-operaciones.shtml>.

<sup>105</sup> Summers, Michael R.: *Analyzing Operations in Business; Issues, Tools & Techniques*. Greenwood Press. Westport, CT, USA, 1998.

<sup>106</sup> The national systems on strategic planning, budget, treasury, accounting, public procurement and State contracting, human resources management, public investment, data processing and control.

are therein organized, in order to regulate the use of their resources and promoting use efficacy and efficiency.<sup>107</sup>

To this end, the decentralization process exceeds the definition and transference of competencies and functions among the different governmental levels, since it implies significant institutional changes on the basis of the redefinition of these entities' roles, as well as new administrative structures in every governmental level. That is, the **institutional reordering** of the State.<sup>108</sup> This document will develop the balance of the first and second, while the need of the third will appear in their contents.

## 2.4 Regulatory Framework for Institutional Reordering

### 2.4.1 Decentralization Policy Legal Framework

The constitutional amendment act for decentralization,<sup>109</sup> which initiated the decentralization process in March, 2002, regulated the State's structure and organization with three governmental levels: National, regional and local. In addition, it defines the roles, competencies and constitutional functions as well as the economic and financial regimes of local and regional governments. Likewise, it established that *"the decentralization process is done by stages, progressively and orderly, in compliance with the criteria that allows an adequate assignment of competencies and transference of resources from the national government to local and regional governments."*<sup>110</sup> Thus, upon starting the process, it was stated that an adequate competency assignment was necessary among every government level.

Four months later, the Decentralization Bases Law<sup>111</sup> regulated region and municipality creation as well as the nature of their political, administrative and economic autonomy, in addition to setting competencies among the three governmental levels and determined the regional and local governmental functions and administrative economic regimes. Likewise, it established three competency types: a) Exclusive, whose sole and exclusive exercise belongs to each governmental level, in compliance with the Constitution and the law; b) shared, where two or more governmental levels intervene, sharing successive stages of the processes implied and whose specific functions and responsibilities would be stated by law; c) delegable, such as those delegated by a governmental level to other through common agreement, maintaining its ownership and being under the obligation of abstaining itself from decision-making on the delegated matter or function. Furthermore, it defined that each governmental level's competencies were ruled by the Constitution as well as by such law, and that functions and attributions would be stated in the Executive Power's, regional and local governments' organic laws; distinguishing the functions by regulation, ruling, planning, administration, execution,

---

<sup>107</sup> Congreso de la República: *Ley Orgánica del Poder Ejecutivo*; Ley N° 29158. Art. 43° y 46°. Lima, 20 de diciembre de 2007.

<sup>108</sup> Guimaraes, Luisa (2001): Op. cit.

<sup>109</sup> Congreso de la República: *Ley de modificación constitucional del capítulo XIV título IV sobre descentralización*; Ley N° 27680. Lima, 6 de marzo de 2002.

<sup>110</sup> *Ibíd.*, Art. 188.

<sup>111</sup> Congreso de la República: *Ley de bases de la descentralización*; Ley N° 27783. Lima, 17 de julio del 2002.

monitoring and controlling as well as per investment promotion.<sup>112</sup> It would also determine the fact that public health was a shared competency between the national government and regional and local governments.<sup>113</sup> Finally, it set a *preparatory stage* in the decentralization process, between June and December, 2002, in which a set of laws were to be approved: Organic Laws of the Executive Power, regional governments and municipalities, territory ordering and demarcation. On the other hand, the progress achieved in regards to the transference of functions was expressed by placing health and education transferences at a fourth and last stage.<sup>114</sup>

Although it was vital to comply with the schedule during this preparatory stage, only the Organic Law of Regional Governments<sup>115</sup> was promulgated on time. The mentioned law defined the regional governments' role, competencies and functions, classifying them as exclusive and shared, and stating general and specific sectorial functions. In article 49, it stated the specific functions in health matters, while in the final provisions, it was stated that the transference of health functions would start in January, 2004.<sup>116</sup> On the other hand, in May, 2003, the Organic Law of Municipalities<sup>117</sup> was issued, therein establishing its general and specific competencies and functions, stating the subjects of municipal competency and distinguishing specific exclusive and shared functions for both province municipalities and district municipalities. In article 80, it established specific functions in health, sanitation and healthiness matters, while article 83 assigned the functions regarding supply as well as products and services commercialization, several of which are linked to health such as food, beverages, and supermarkets.

Finally, five years later the Executive Power Organic Law<sup>118</sup> was promulgated, stating the competencies and functions of the National Government's Executive Power and that the exercise of shared competencies among governmental levels was ruled by the Political Constitution of Peru, the Decentralization Bases Law and the organic laws of ministries and Executive Power entities, as well as by regional and local governments. Furthermore, the Executive Power should exercise its competencies without assuming functions and attributions from other governmental levels, not being able to delegate nor transfer functions and attributions inherent to its exclusive competencies. Likewise, it stated that in 4 months, the Executive Power would send to Congress those ministries' organization and functions law proposals, which held only exclusive competencies, and in a 6-month period those corresponding to the ministries holding exclusive and shared competencies.

---

<sup>112</sup> *Ibíd.* Artículos 13, 14 y 15.

<sup>113</sup> *Ibíd.* Artículo 36.

<sup>114</sup> *Ibíd.* Segunda disposición transitoria.

<sup>115</sup> Congreso de la República: *Ley Orgánica de los Gobiernos Regionales; Ley N° 27687*. Lima, 16 de noviembre del 2002.

<sup>116</sup> Congreso de la República: *Ley N° 27902, ley que modifica la Ley Orgánica de los Gobiernos Regionales N° 27687, para regular la participación de los alcaldes provinciales y la sociedad civil en los gobiernos regionales y fortalecer el proceso de descentralización y regionalización*. Lima, 1° de enero del 2003. Cuarta disposición transitoria.

<sup>117</sup> Congreso de la República: *Ley orgánica de municipalidades; Ley N° 27972*. Lima, 27 de mayo del 2003.

<sup>118</sup> Congreso de la República: *Ley Orgánica del Poder Ejecutivo; Ley N° 29158*. Lima, 20 de diciembre de 2007.

**Table No. 1: General Regulations on Decentralization**

Legal Rule	Date of Issue	Main Provisions	Transitory Provisions
Constitutional amendment act chapter XIV title IV on decentralization; Law No. 27680 <sup>119</sup>	March, 2002	<ul style="list-style-type: none"> <li>Regulates the State's structure and organization with 3 governmental levels: National, regional and local.</li> <li>Defines constitutional competencies and functions as well as the economic and patrimonial regime of regional and local governments.</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>
Decentralization Bases Law; Law No. 27783 <sup>120</sup>	July, 2002	<ul style="list-style-type: none"> <li>States the competencies of the three governmental levels and determines the regional and local governments' functions and administrative economic regime.</li> <li>Defines 3 types of competencies: Exclusive, shared and delegable.</li> <li>Regulates the government's relationships amongst its different levels.</li> <li>Determines public health as a shared competency among the three governmental levels.</li> </ul>	<p>Stages of the process:</p> <ul style="list-style-type: none"> <li>Preparatory stage, between June and December, 2002 to approve the legal framework.</li> <li>1<sup>st</sup> stage: Regional and local government installation and organization.</li> <li>2<sup>nd</sup> stage: Consolidation of the regionalization process.</li> <li>3<sup>rd</sup> stage: Transference of sectorial competencies, except for health and education, to regional and local governments.</li> <li>4<sup>th</sup> stage: Education and health transference to regional and local governments.</li> </ul>
Organic Law of Regional Governments; Law No. 27867 <sup>121</sup>	November, 2002	<ul style="list-style-type: none"> <li>Establishes the regional governments' purpose, structure, organization, competencies and functions, classifying them as exclusive and shared, as well as stating general and specific sectorial functions.</li> <li>States the sector guiding policy and regional management principles.</li> <li>Regulates the gradual transference process for competencies, functions, attributions, resources and regional government budget through transference sectorial competencies plans and public management training plans, formulated</li> </ul>	The transference process would be approved by means of a Supreme Decree, before December 31, 2002 with a favorable report from the National Council for Decentralization.

<sup>119</sup> Congreso de la República: *Ley de modificación constitucional del capítulo XIV título IV sobre descentralización; Ley N° 27680*. Lima, 6 de marzo de 2002.

<sup>120</sup> Congreso de la República: *Ley de bases de la descentralización; Ley N° 27783*. Lima, 17 de julio del 2002.

<sup>121</sup> Congreso de la República: *Ley Orgánica de los Gobiernos Regionales; Ley N° 27687*. Lima, 16 de noviembre del 2002.

Legal Rule	Date of Issue	Main Provisions	Transitory Provisions
		<p>by ministry transference commissions, instituting an accreditation system prior to the transference to be approved by a specific law.</p> <ul style="list-style-type: none"> <li>• In article 10 establishes public health as a shared competency.</li> <li>• In article 49 establishes the specific functions in health matters.</li> </ul>	
Law modifying the Organic Law of Regional Governments; Law No. 27902 <sup>122</sup>	January, 2003	<ul style="list-style-type: none"> <li>• Establishes the agreement of regional government policies and functions with sector policies.</li> <li>• Assigns sectorial functions to the regional management body responsible for economic development, social development, planning, budget and territory conditioning, natural resources and environment, and infrastructure.</li> </ul>	<ul style="list-style-type: none"> <li>• Defines the regional sector directorates' regime as bodies responsible for implementing national and regional sector policies, which are under the sector's direction as well as for the relevant regional management, to whom they respond on their management.</li> <li>• Establishes the screening process for regional sector directors through public bids, called on by regional governments in coordination with the National Government.</li> <li>• States that in January, 2004, health sector transferences should have started.</li> </ul>
Organic Law of Municipalities; Law No. 27972. <sup>123</sup>	May, 2003	<ul style="list-style-type: none"> <li>• Establishes specific and shared functions of province and district municipalities.</li> <li>• Regulates the transference process and creates the Accreditation System of Local Governments.</li> <li>• In Article 80, establishes specific health-related functions.</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>
Law regulating the transitory regime of regional sector directorates of regional	December, 2006	<ul style="list-style-type: none"> <li>• States that regional management is responsible for regional policies and holds sector directorates determining each regional government.</li> <li>• Establishes that regional sector</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>

<sup>122</sup> Congreso de la República: *Ley N° 27902, ley que modifica la Ley Orgánica de los Gobiernos Regionales N° 27687. para regular la participación de los alcaldes provinciales y la sociedad civil en los gobiernos regionales y fortalecer el proceso de descentralización y regionalización.* Lima, 1° de enero del 2003.

<sup>123</sup> Congreso de la República: *Ley orgánica de municipalidades; Ley N° 27972.* Lima, 27 de mayo del 2003.

Legal Rule	Date of Issue	Main Provisions	Transitory Provisions
governments; Law No. 28926 <sup>124</sup>		directorates are bodies dependent on the relevant regional management. It is in charge of the specific functions of a sector in the regional government realm. It is in charge of regional directors who are in a position of trust.	
Executive Power Law; Law No. 29158 <sup>125</sup>	December, 2007	<ul style="list-style-type: none"> <li>Establishes the basic principles and rules on organization, competencies and functions of the Executive Power as part of the National Government.</li> <li>Establishes that the exercise of the competencies shared between the Executive Power and regional and local governments should follow by the Political constitution of Peru, the Decentralization Bases Law and the organic laws of the ministries, Executive Power and regional and local entities.</li> <li>Establishes that the transference of competencies, resources and functions from entities to regional and local governments is done following decentralization rules, which states the responsibility of each governmental level, coordination manners and re-dimensioning of functions and responsibilities.</li> <li>Establishes the competency principle that states that the Executive Power exercises its competencies without assuming functions and attributions of other governmental levels, enabling it from transferring or delegating functions and attributions inherent to its exclusive competencies.</li> </ul>	<ul style="list-style-type: none"> <li>Establishes that in 4 months the Executive Power would send to Congress the organization and functions law proposals from the ministries which held only exclusive competencies, and in a 6-month period those corresponding to the ministries holding exclusive and shared competencies.</li> </ul>

## 2.4.2 Regulatory Framework for the transference of Responsibilities

An ordered transference of responsibilities requires two essential conditions: a) to be supported by a clear competency delimitation and distribution of functions among the different levels; b) a consistent regulation of the planning processes, capacity accreditation, creation of a clear ownership of roles and responsibilities to be transferred, resource transference and operative instruments linked to these functions to enable an appropriate institutional performance at every receiving governmental level. Unfortunately, as has already been stated in the previous section,

<sup>124</sup> Congreso de la República: *Ley que regula el régimen transitorio de las direcciones regionales sectoriales de los gobiernos regionales*; Ley N° 28926. Lima, 8 de diciembre de 2006.

<sup>125</sup> Congreso de la República: *Ley Orgánica del Poder Ejecutivo*; Ley N° 29158. Lima, 20 de diciembre de 2007.

the promulgation of the competencies delimitation legal framework has been insufficient, suffering from delays and being inconsistent. Consequently, the decentralization process development has followed an inverse sequence to the one required: 1) A first stage consistent with the regulatory framework of the transference of functions process to regional and local governments; 2) a second regulatory stage oriented towards competency delimitation and functions distribution. It is evident that this asynchrony in the process of responsibilities transference has had significant consequences in the process and in explaining several limitations presented.

The first development stage of the regulatory framework in the functions transference process, addressed to establishing the necessary conditions and to regulate it, is initiated with the promulgation of the Law on the Accreditation System of Regional and Local Governments<sup>126</sup> and its regulation,<sup>127</sup> aimed at defining the general and specific requirements, management indicators, verifying mechanisms on compliance of accreditation requirements and later certification, so as to guarantee institutional capacity building for exercising the functions to be transferred. It was also established that the transference process to regional governments be held through middle-term sector transference plans with a five-year projection and of referential character for preparing annual plans. Presidential Resolution No. 081-CND-P-2005 established the procedures for sector transference plans; these middle-term plans should result from the consensus on sector competencies transference proposals and regional and local governments' transference requests. For this purpose, the regulation established the need to identify transference-related sectorial functions, taking as a reference the competencies assigned by the Bases Law and developed by the LOGR. As a relevant note, it is worth mentioning that, with the exception of the health sector where a great consensus work took place for preparing middle-term plans, no consensus experiences were verified to prepare these plans in other sectors. Finally, it was stated that the regional governments' (PAP, CAP, ROF, MOF, TUPA) management documents were to be adapted according to the functions being transferred. This regulation was current and was applied in 2005 and in the first semester of 2006, since it was linked to the 2005 execution transference plan (Presidential Resolution No. 050-CND-P-2005 and Presidential Resolution No. 081-CND-P-2005).

Nonetheless, following the so-called “*decentralization shock*” launched at the end of 2006 by means of Supreme Decree No. 068-2006-PCM, the Decentralization Secretariat Resolution No. 003-2007-PCM/SD as well as the Decentralization Secretariat Resolution No. 025-2007-PCM/SD), promulgated so as to speed up the process of functions transference and end it on December 31, 2007. This regulatory framework established the guidelines for the transference of resources associated to functions (financial and human resources) as well as the subscription of management agreements between regional governments and relevant sectors for accompaniment and technical assistance in the exercise of the transferred functions. The completion of the process of sectorial functions transference to regional governments establishes the closure of this first stage.

---

<sup>126</sup> Congreso de la República: *Ley del Sistema de Acreditación de los Gobiernos Regionales y Locales*; Ley N° 28273. Lima, 8 de julio de 2004.

<sup>127</sup> Congreso de la República: *Reglamento de la Ley N° 28273 - Ley del Sistema de Acreditación de los Gobiernos Regionales y Locales*; aprobado por Decreto Supremo N° 080-2004-PCM. Lima, 15 de noviembre de 2004.

The second stage involving the development of the competencies and functions delimitation matrixes among governmental levels started with the promulgation of the Executive Power Organic Law (LOPE), conditioning the need to precisely establish functions and faculties of each governmental level, mainly the national level, so as to formulate their respective organization and sectorial functions laws (LOF) by means of Ministerial Resolution No. 111-2008-PCM which approves Directive No. 002-2008-PCM/SGP. At this stage, the guidelines for the formulation of laws for the relevant ministries in terms of organization and functions are established regarding not only exclusive competencies but also shared competencies. Thus, Directive No. 003-2008-PCM/SGP<sup>128</sup> established the purpose and methodology for the formulation and approval of competencies delimitation and functions distribution matrixes among governmental levels, based on identifying sector competency-based matters, essential processes regarding these competencies and finally the attributions (regulation, planning, administration, execution, monitoring, assessment and financing) as well as functions for each of these processes. Each sector had to elaborate a matrix showing their current status regarding the situation of functions distribution at each governmental level and, in turn, formulate a proposal on the new distribution of functions. Matrixes development and their subsequent approval turned to be mandatory upon the issuance of Supreme Decree No. 049-2009-PCM. Likewise, the matrixes had to pass through consultation, prior to their approval, by both regional and local governments. In addition, it was established that those ministries with a law of organization and functions promulgated prior to the formulation of this supreme decree should consult their respective matrixes and its subsequent approval as a main requirement to elaborate and approve their organization and functions By-laws.

Finally, the regulatory framework related to both the definition of guidelines and procedures for the transference of resources associated to the transferred functions, establishing as instruments every fund, program, project, company and infrastructure linked corresponding to national governmental entities. In the case of the health sector, management pilot programs were considered an additional instrument category. This stage also involves the development of a framework required for the delegation of competencies as a step prior to the transference. Finally the regulatory framework was stated to develop the human resources transference process from the national government to regional and local governments.

---

<sup>128</sup> Presidencia del Consejo de Ministros: *Resolución Ministerial que aprueba la elaboración de las Matrices de delimitación de competencias y distribución de funciones y los ante proyectos de LOF de los ministerios que tienen a su cargo competencias exclusiva y compartidas.*; Resolución Ministerial N° 188-2008-PCM. Lima, 13 de junio de 2008.

**Table No. 2: Statutory regulations on responsibility transfer**

Legal Rule	Date of Issue	Main Provisions
Law on the Accreditation System of Regional and Local Governments; Law No. 28273 <sup>129</sup>	July 8, 2004	<ul style="list-style-type: none"> <li>Regulates the Accreditation System to guarantee the transference of competencies, functions, attributions and resources from the National Government to regional and local governments, and to optimize public services' quality.</li> <li>Establishes the transference process through the formulation of plans per sector.</li> </ul>
Statutory Regulations of Law on the Accreditation System of Regional and Local Governments <sup>130</sup>	November 15, 2004	<ul style="list-style-type: none"> <li>Establishes that the accreditation process is initiated annually with the approval and publication of the relevant annual plans.</li> <li>Defines the accreditation process cycle for transferring sectorial functions and the corresponding personnel, documentation, goods and budget resources.</li> <li>States that in order to certify their accreditation, regional and local governments must comply with general and specific requirements, as detailed in the Regulation appearing in Art. 21 and 22.</li> </ul>
Presidential Resolution No. 050-CND-P-2005 approving Directive No. 03-CND-P-2005 <sup>131</sup>	August 11, 2005	<ul style="list-style-type: none"> <li>Approves the "Statutory Guidelines for the transference of funds, social projects, social programs for the fight against poverty, regional productive infrastructure investment and sectorial functions to regional and local governments in 2005, as included in S.D. No. 052.2005-PCM."</li> <li>Exceptionally regulates the accreditation process for the 2005 Annual Plan transference, whose accreditation process should have been developed between August, 2005 and March, 2006.</li> <li>Taking into consideration the fact that the specific requirements were not included in the 2005 Annual Plan, said rule incorporated the specific requirements' approval stage to be in place no later than September 7, 2005.</li> </ul>
Presidential Resolution No. 081-CND-P-2005 approving Directive No. 05-CND-P-2005 <sup>132</sup>	December 24, 2005	<ul style="list-style-type: none"> <li>Establishes procedures for the formulation of sector transference plans.</li> <li>States that the sector transference plans are approved by means of a ministerial resolution for the relevant sector.</li> </ul>

<sup>129</sup> Congreso de la República: *Ley del Sistema de Acreditación de los Gobiernos Regionales y Locales*; Ley N° 28273. Lima, 8 de julio de 2004.

<sup>130</sup> Congreso de la República: *Reglamento de la Ley N° 28273 - Ley del Sistema de Acreditación de los Gobiernos Regionales y Locales*; aprobado por Decreto Supremo N° 080-2004-PCM. Lima, 15 de noviembre de 2004.

<sup>131</sup> Consejo Nacional de Descentralización: *Resolución Presidencial N° 050-CND-P-2005 que aprueba la Directiva N° 03-CND-P-2005 "Normas para la ejecución de la transferencia del año 2005 a los gobiernos regionales y locales, de los fondos y proyectos sociales, programas sociales de lucha contra la pobreza, proyectos de inversión en infraestructura productiva de alcance regional y funciones sectoriales, incluidos en el DS N° 052-2005-PCM"*. Lima, 11 de agosto de 2005.

<sup>132</sup> Consejo Nacional de Descentralización: *Resolución Presidencial N° 081-CND-P-2005 que aprueba la Directiva N° 05-CND-P-2005, "Procedimiento para la formulación de los planes de transferencia sectoriales de mediano plazo y de los planes anuales de transferencia de competencias sectoriales a los gobiernos regionales y locales"* Lima, 24 de diciembre de 2005.

Legal Rule	Date of Issue	Main Provisions
Supreme Decree No. 068-2006-PCM <sup>133</sup>	October 13, 2006	<ul style="list-style-type: none"> <li>Establishes the provisions related to the conclusion of programmed transferences to regional and local governments, setting the deadline on December 31, 2007.</li> <li>Establishes the identification and quantification of budget resources associated with functions, funds, programs and projects to be transferred to regional and local governments, in compliance with the principle of neutrality on resource transference as stated in Article 5 of the Decentralization Bases Law.</li> <li>States that health transference should comprise 50 faculties of 13 LOGR functions.</li> </ul>
Decentralization Secretariat Resolution No. 003-2007-PCM/SD approving Directive No. 001-2007/PCM-SD <sup>134</sup>	May 17, 2007	<ul style="list-style-type: none"> <li>Establishes the methods, procedures and deadlines to conduct the transference of sectorial functions contained in the Organic Law of Regional Governments included in the "2007 Annual Plan of Sectorial Competencies Transfer to Regional and Local Governments," as well as pending sectorial functions included in the 2004, 2005 and 2006 plans, which are included in the 2007 Annual Plan.</li> </ul>
Decentralization Secretariat Resolution No. 025-2007-PCM/SD approving Directive No. 006-2007/PCM-SD <sup>135</sup>	September 25, 2007	<ul style="list-style-type: none"> <li>Establishes the main procedures and specific deadlines to facilitate the effectuation transfer of the sectorial functions process in favor of regional governments, as stated in Directive 001-2007/PCM-SD.</li> </ul>
Ministerial Resolution No. 067-2008/MINSA	February 8, 2008	<ul style="list-style-type: none"> <li>A work group is formed head the LOPE implementation at the Ministry of Health.</li> </ul>
Ministerial Resolution No. 111-2008-PCM approving Directive No. 002-2008-PCM/SGP <sup>136</sup>	April 10, 2008	<ul style="list-style-type: none"> <li>Establishes the guidelines to elaborate bills on organization and functions for ministries that are solely in charge of exclusive competencies.</li> </ul>

<sup>133</sup> Poder Ejecutivo: *Establece disposiciones relativas a la culminación de las transferencias programadas a los gobiernos regionales y locales, disponiendo el plazo del 31 de diciembre de 2007*; Decreto Supremo N° 068-2006-PCM. Lima, 13 de octubre de 2006.

<sup>134</sup> Presidencia del Consejo de Ministros / Secretaría de Descentralización: *Resolución Presidencial N° 003-2007-PCM/SD que aprueba la Directiva N° 001- 2007/PCM-SD," Normas para la Ejecución de la Transferencia del año 2007 a los Gobiernos Regionales y Locales, de las Funciones Sectoriales incluidas en los Planes Anuales de Transferencia"*. Lima, 17 de mayo de 2007.

<sup>135</sup> Presidencia del Consejo de Ministros / Secretaría de Descentralización: *Resolución Presidencial N° 025-2007-PCM/SD que aprueba la Directiva N° 006- 2007/PCM-SD "Normas para la efectivización del proceso de transferencia del año 2007 de los sectores del gobierno nacional a los gobiernos regionales"*. Lima, 25 de septiembre de 2007.

<sup>136</sup> Presidencia del Consejo de Ministros: *Aprueba Directiva "Lineamientos para la elaboración de Proyectos de Leyes de Organización y Funciones de los Ministerios que tienen a su cargo únicamente competencias exclusivas; Resolución Ministerial N° 111-2008-PCM*. Lima, 10 abril de 2008.

Legal Rule	Date of Issue	Main Provisions
Ministerial Resolution No. 188-2008-PCM approving Directive No. 003-2008-PCM/SGP <sup>137</sup>	June 13, 2008	<ul style="list-style-type: none"> <li>Establishes the guidelines to elaborate bills on organization and functions for ministries in charge of shared competencies.</li> <li>Establishes the guidelines to elaborate competencies delimitation and functions distribution matrices, as well as LOF bills from the Executive Power, aimed at guaranteeing its compliance with LOPE, Decentralization Bases Law, Organic Laws of regional and local governments, as well as the Framework Law for Production and Legislative Systematization and its statutory regulation.</li> <li>Provides a detailed account on the ministries having to formulate competency delimitation and functions distribution matrices, clearly identifying the responsibilities the ministries and their public bodies must comply and which are relevant to regional and local governments.</li> <li>States that these matrices should match their essential processes (provision of services or regulation and promotion of a determined social or economic competency-related activity), which should be the basis of the formulation of the ministries' LOF projects, which should bear favorable technical opinion from the PDM's Public Management Secretariat.</li> <li>Establishes that matrices should be consulted together with regional and local governments.</li> </ul>
Decentralization Secretariat Resolution No. 060-2008-PCM/SD <sup>138</sup>	November 14, 2008	<ul style="list-style-type: none"> <li>Extends the coming into force of Directive No. 001-2007/PCM-SD, which regulates and rules the transference of sectorial functions to regional governments on those mentioned in the 2008 Transference Plan.</li> <li>Establishes the application of a simplified transference procedure as well as the criteria and guidelines to conduct the four stages established in the mentioned Directive.</li> </ul>
Supreme Decree No. 049-2009-PCM <sup>139</sup>	July 23, 2009	<ul style="list-style-type: none"> <li>Dictates provisions for the approval of competencies delimitation and functions distribution matrices of those ministries in charge of exclusive and shared competencies.</li> <li>In Art. 1, it establishes that by means of a Supreme Decree, the Ministries holding exclusive and shared competencies should approve, in a period not longer than 60 working days following the LOF's approval, their relevant competency delimitation and functions distribution matrices.</li> <li>In Art. 2, it states that for such approval, it is necessary to hold a previous consultation with regional and local governments and the favorable SGP report, with prior opinion of the Decentralization Secretariat.</li> <li>States that the mentioned approval will constitute a vital requirement for ROF approval by the ministries.</li> </ul>

<sup>137</sup> Presidencia del Consejo de Ministros: *Resolución Ministerial que aprueba la elaboración de las Matrices de delimitación de competencias y distribución de funciones y los ante proyectos de LOF de los ministerios que tienen a su cargo competencias exclusiva y compartidas.*; Resolución Ministerial N° 188-2008-PCM. Lima, 13 de junio de 2008.

<sup>138</sup> Presidencia del Consejo de Ministros / Secretaría de Descentralización: *Extiende vigencia de la Directiva N° 001-2007/PCM-SD que norma y regula la transferencia de funciones sectoriales a los gobiernos regionales a las comprendidas en el Plan de Transferencia 2008*; Resolución de Secretaría de Descentralización N° 060-2008-PCM/SD. Lima, 14 de noviembre de 2008.

<sup>139</sup> Poder Ejecutivo: *Decreto supremo que dicta disposiciones para la aprobación de las matrices de delimitación de competencias y distribución de funciones de los ministerios que tienen a su cargo competencias exclusiva y compartida*; Decreto Supremo N° 049-2009-PCM s. Lima, 23 de julio de 2009.

Legal Rule	Date of Issue	Main Provisions
Decentralization Secretariat Resolution No. 059-2009-PCM/SD <sup>140</sup>	November 12, 2009	<ul style="list-style-type: none"> <li>Establishes the guidelines and procedures applicable to the transference of funds, programs, projects, companies, infrastructure and other operational instruments associated with the functions transferred to regional and local governments, as well as the use of competency delegation among governmental levels in the framework of the decentralization process.</li> </ul>
Supreme Decree No. 040-2010-PCM <sup>141</sup>	March 28, 2010	<ul style="list-style-type: none"> <li>Approves the regulation for human resources transference from the national government to regional and local governments.</li> </ul>

### 2.4.3 Regulatory Framework for Institutional Adaptation

The development of the regulatory framework on which the institutional adaptation processes have occurred in the instances of regional governments can be divided in three stages. The first stage defines the process' purpose and the general concepts, establishing the conditions for its development. The second stage establishes the regulatory framework, both general and sectorial, mainly in the formulation of guidelines and criteria for organizational adaptation. Finally, the third stage promotes the creation of national instances facilitating State administration mainly in human resources management and in the planning process.

The first stage takes as a starting point the State Modernization Law, Law No. 27658, whose purpose is to improve the State's efficiency. One of the central mechanisms therein established is decentralization that, starting from a constitutional amendment, becomes a national realm and mandatory policy. Furthermore, the Decentralization Bases Law and the Organic Law of Regional Governments establish the three governmental levels and the functions of each one of them. Regional governments are granted the autonomy to define and approve their organization. From an organizational stand point, the previously-mentioned regulatory framework established the organizational guidelines and criteria assigning the power to exercise sectorial functions to the regional management of regional governments. In the specific case of the health function (as a shared function), Regional Health Directorates became responsible for implementing national and regional sectorial policies, being left under the sector's direction and under the relevant regional management. This double dependency undermined the autonomy of regional governments to approve the organization of their regional sector directorates as well as of their personnel assignment charts, which had to be consulted with the relevant ministry. Likewise, it was established that the screening of regional sector directors had to be clearly owned by those ministries.

<sup>140</sup> Presidencia del Consejo de Ministros / Secretaría de Descentralización: *Aprueba Directiva 004-2009-PCM/SD "Directiva para la transferencia de fondos, programas, proyectos, empresas, infraestructura y otros instrumentos operativos asociados a las funciones transferidas a los gobiernos regionales y locales, y la utilización de la delegación de competencias entre niveles de gobierno, en el marco del proceso de descentralización; Resolución de Secretaría de Descentralización N° 059-2009-PCM/SD. Lima, 12 noviembre 2009.*

<sup>141</sup> Poder Ejecutivo: *Aprueban reglamento para la transferencia de recursos humanos del gobierno nacional a los gobiernos regionales y locales; Decreto Supremo N° 040-2010-PCM. Lima, 28 de marzo de 2010.*

However, during this same period, MINSA established a regulatory framework, regulating in a standardized manner for the entire country, the organizational aspects of the Regional Health Directorates and established their health authority character in the region by delegating MINSA's High Authority. Both Ministerial Resolution No. 573-2003-SA/DM and Ministerial Resolution No. 638-2003 SA/DM generated competency conflict with the Organic Law of Regional Governments regarding their autonomy on regulatory matters for internal organization. During this period, MINSA recognized 34 health directorates nationwide.

In the second stage, MINSA passes the organizational guidelines for adapting the organization of Regional Health Directorates, which include organizational model proposals, modifying the previously established regulatory provisions and providing a greater degree of flexibility in the Regional Health Directorates' reorganizational process. A relevant aspect was the persistence of competency conflict in place between MINSA's sectorial regulations and regional governments' administrative autonomy with regard to organizational aspects, as stated in its organic law. In an almost parallel manner, both PCM and Congress passed a general character legal framework for institutional adaptation and the elaboration of an Organization and Functions By-law (ROF) for public entities, not only national and regional but also local. Within this framework, regional governments' autonomy to organize their sectorial functions are reinforced and the organic dependency of regional sector directorates from their relevant regional managements is consolidated, as stated by the Law regulating the transitory regime of regional governments' regional sector directorates; Law No. 28926.

Finally, by the end of 2007 the Executive Power Organic Law (LOPE), Law No. 29158 is passed, therein providing the principles and basic organizational, competencies and functions regulations of the Executive Power and stating that it should fulfill its competencies without assuming the functions of the other governmental levels. Nonetheless the time elapsed since then, the new MINSA's Law of Organization and Functions (LOF) is not currently approved.

In the third stage, a number of legislative decrees creating the National Civil Service Authority, governing the Administration System in Human Resources Management, public managers group, National Strategic Planning System and National Strategic Planning Center (CEPLAN), as part of an effort aimed at the continuous improvement of the State's administration. Furthermore, Legislative Decree No. 1025-2008 provides the rules for State-oriented personnel training and evaluation.

On the other hand, in regards to strengthening institutional capacities for exercising sectorial functions transferred to regional governments, key component for institutional adaptation, the legal framework in the decentralization process defined it as a national priority; although at the beginning it had a restricted focus on personnel training programs. Thus, it is worth stating that the stated purpose of institutional adaptation should have been more comprehensive, understood as a set of interventions destined to improve institutional performance in the exercise of the functions transferred, by improving the number of institutional capacities including organization, infrastructure, equipment, technology, support systems and human resources. For this reason, it is recommended to clearly differentiate the institutional strengthening process on training interventions since these are part of the general strengthening process.

To this end, the Decentralization Bases Law provided the need to develop training plans to improve the exercise of the functions to be transferred. Furthermore, in 2004, the Accreditation

System Law provided that it was necessary to develop a training and technical assistance process for exercising the functions transferred,<sup>142</sup> and also it attributed the responsibility of regional and local governments to develop the capacity management needed and as the national government's responsibility to grant the relevant training and technical assistance.<sup>143</sup> It is worth stating that upon deactivating the CND, the PCM's Decentralization Secretariat assumed this responsibility.

In order to develop a proposal ordering the capacity-strengthening process, Supreme Decree No. 002-2008-PCM was passed, forming a multi-sector commission for regional and municipal capacity building, responsible of formulating the national plan for capacity building on public management and good governance, whose product was finally approved by means of Supreme Decree No. 004-2010-PCM. Equally, new regulations and norms were created, among which the National Civil Service Authority (SERVIR) as well as Supreme Decree No. 047-2009-PCM were created, providing guidelines for capacity building in the framework of a decentralized public management model and the formulation of sector plans for capacity building in ministries.

Finally, in March, 2011, the Decentralization Secretariat issues Directive No. 154-2011-PCM/SD for the formulation, approval, implementation, monitoring and assessment of capacity-building plans. Its focus comprises the strengthening of the different types of institutional capacities for the exercise of the functions transferred. Nonetheless, in March of that same year, SERVIR passes a "Directive for the Preparation of the Development Plan for State-Serving People," focused only the capacities of human resources and not in other institutional capacities.

**Table No. 3: Regulation on Institutional Adaptation**

Legal Rule	Date of Issue	Main Provisions
Framework Law for the Modernization of National State Management; Law No. 27658 <sup>144</sup>	January 17, 2002	<ul style="list-style-type: none"> <li>• Its purpose is to improve public management and build a democratic, decentralized State for citizen service, to obtain greater efficiency levels in the State system.</li> <li>• Article 6.- Provides the design and structure criteria of Public Administration, as well as its dependencies, entities and directorates.</li> <li>• Promotes process development within the legal framework, non-duplicity in the exercise of functions, the specialization principle for organizational design, clear definition of functions in order to facilitate performance assessment.</li> <li>• Promotes the subscription of Management Agreements and the implementation of Modernization Pilot Programs in the different Central Public Administration sectors, in all instances, in compliance with the provisions stated in this Law. The latter imply a comprehensive reorganization of the sector, including functional, structural and human resources aspects, among others.</li> </ul>

<sup>142</sup> Congreso de la República: *Ley del sistema de acreditación de los gobiernos regionales y locales*. Op. cit., artículo 2.

<sup>143</sup> *Ibíd.* Artículo 6.

<sup>144</sup> Congreso de la República: *Ley marco de modernización de la gestión del Estado*; Ley N° 27658. Lima, 17 de enero del 2002.

Legal Rule	Date of Issue	Main Provisions
Constitutional Amendment Law on Chapter XIV title IV on Decentralization; Law No. 27680 <sup>145</sup>	March, 2002	<ul style="list-style-type: none"> <li>States regional governments' constitutional competencies, among which there is defining its organization.</li> <li>Article 192.- Regional governments promote regional development and economy, investments, activities and public services under their responsibility, in agreement with national and local development policies and plans.</li> </ul>
Decentralization Bases Law; Law No. 27783 <sup>146</sup>	July, 2002	<ul style="list-style-type: none"> <li>Sets the competencies of the three governmental levels and determines the functions and administrative- economic regime of regional and local governments.</li> <li>Defines 3 competency types: Exclusive, shared and delegable, determining public health as a shared competency.</li> <li>Establishes the exclusive functions of regional governments:</li> <li>States administrative autonomy as the faculty for internal organization, to determine and to regulate public services of their responsibility.</li> <li>Article 35.- Exclusive competencies: c) To approve their internal organization as well as their institutional budget.</li> <li>Entrusts the preparation of the "Capacity-building Plan at Regional and Municipal Levels."</li> <li>States the need to strengthen administrative management systems at the national, regional and local levels: Budget, Personnel, Treasury, Accounting, Credit, Public Procurement and State Contracting, and Public Investment.</li> </ul>
Organic Law of Regional Governments; Law No. 27867 <sup>147</sup>	November, 2002	<ul style="list-style-type: none"> <li>In Article 10, it states public health as a shared competency.</li> <li>In Article 49, it states specific functions in health-related matters.</li> <li>States the basic organic structure of regional governments: Regional Council, Regional Presidency, Regional Coordination Council, as well as its Executive Body: General Management and Economic Development Regional Managements, Social Development, Planning, Budget and Territory Conditioning, Infrastructure, Natural Resources and Environmental Management.</li> </ul>
Amendment Law to the Organic Law of Regional	January, 2003	<ul style="list-style-type: none"> <li>Assigns sectorial functions to the Economic Development Regional Management, Social Development, Planning, Budget and Territory</li> </ul>

<sup>145</sup> Congreso de la República: *Ley de modificación constitucional del capítulo XIV título IV sobre descentralización; Ley N° 27680*. Lima, 6 de marzo de 2002.

<sup>146</sup> Congreso de la República: *Ley de bases de la descentralización; Ley N° 27783*. Lima, 17 de julio del 2002.

<sup>147</sup> Congreso de la República: *Ley Orgánica de los Gobiernos Regionales; Ley N° 27687*. Lima, 16 de noviembre del 2002.

Legal Rule	Date of Issue	Main Provisions
Governments; Law No. 27902 <sup>148</sup>		<p>Conditioning, Natural Resources and Environmental Management and Infrastructure. States that functions in health-related matters is relevant to the Social Development Regional Management.</p> <ul style="list-style-type: none"> <li>• Defines the regime of regional sector directorates as bodies responsible for implementing national and regional sector policies and that they are under the directorate of the sector and of the relevant regional management, to whom they respond for their management.</li> </ul>
Organic Law of Regional Governments; Law No. 27867 <sup>149</sup>	November, 2002	<ul style="list-style-type: none"> <li>• In Article 10, it states public health as a shared competency.</li> <li>• In Article 49, it states specific functions in health-related matters.</li> <li>• States the basic organic structure of regional governments: Regional Council, Regional Presidency, Regional Coordination Council, as well as its Executive Body: General Management and Economic Development Regional Managements, Social Development, Planning, Budget and Territory Conditioning, Infrastructure, Natural Resources and Environmental Management.</li> </ul>
Amendment Law to the Organic Law of Regional Governments; Law No. 27902 <sup>150</sup>	January, 2003	<ul style="list-style-type: none"> <li>• Assigns sectorial functions to the Economic Development Regional Management, Social Development, Planning, Budget and Territory Conditioning, Natural Resources and Environmental Management and Infrastructure. States that functions in health-related matters is relevant to the Social Development Regional Management.</li> <li>• Defines the regime of regional sector directorates as bodies responsible for implementing national and regional sector policies and that they are under the directorate of the sector and of the relevant regional management, to whom they respond for their management.</li> </ul>
Organic Law of Regional Governments; Law No. 27867 <sup>151</sup>	November, 2002	<ul style="list-style-type: none"> <li>• In Article 10, it states public health as a shared competency.</li> <li>• In Article 49, it states specific functions in health-related matters.</li> <li>• States the basic organic structure of regional governments: Regional Council, Regional Presidency, Regional Coordination Council, as well as its Executive Body: General Management and Economic Development Regional Managements, Social Development, Planning, Budget and Territory Conditioning, Infrastructure, Natural Resources and Environmental Management.</li> </ul>

<sup>148</sup> Congreso de la República: *Ley N° 27902, ley que modifica la Ley Orgánica de los Gobiernos Regionales N° 27687. para regular la participación de los alcaldes provinciales y la sociedad civil en los gobiernos regionales y fortalecer el proceso de descentralización y regionalización.* Lima, 1° de enero del 2003.

<sup>149</sup> Congreso de la República: *Ley Orgánica de los Gobiernos Regionales; Ley N° 27687.* Lima, 16 de noviembre del 2002.

<sup>150</sup> Congreso de la República: *Ley N° 27902, ley que modifica la Ley Orgánica de los Gobiernos Regionales N° 27687. para regular la participación de los alcaldes provinciales y la sociedad civil en los gobiernos regionales y fortalecer el proceso de descentralización y regionalización.* Lima, 1° de enero del 2003.

<sup>151</sup> Congreso de la República: *Ley Orgánica de los Gobiernos Regionales; Ley N° 27687.* Lima, 16 de noviembre del 2002.

Legal Rule	Date of Issue	Main Provisions
Supreme Decree No. 043-2004-PCM <sup>152</sup> , approving the guidelines for the elaboration and approval of the Personnel Assignment Chart (CAP) for public administration entities	June 17, 2004	<ul style="list-style-type: none"> <li>States the general guidelines that every Public Sector entity (National Government, Regional or Local Governments) should follow for the elaboration and approval of the Personnel Assignment Chart (CAP).</li> <li>Promotes a correct position definition, according to the organic structure of entities and to the public administration design and structure criteria, in compliance with Law No. 27658, Framework Law for the Modernization of National State Management, in order to prioritize and optimize the use of public resources.</li> </ul>
Law on the Accreditation System of Regional and Local Governments; Law No. 28273 <sup>153</sup>	July 8, 2004	<ul style="list-style-type: none"> <li>Reiterates the need to strengthen administrative management systems at national, regional and local levels.</li> </ul>
Regulation on the Law on the Accreditation System of Regional and Local Governments, therein approved by means of Supreme Decree No. 080-2004-PCM <sup>154</sup>	November 15, 2004	<ul style="list-style-type: none"> <li>States as a policy the provision of training and technical assistance before, during and after sectorial functions transfer. For the conduction of training and technical assistance, the national level will be responsible for their compliance, with arrangements to the contents of the "National Training and Technical Assistance Plan on Public Management for Strengthening Regional and Local Governments" countersigned by Supreme Decree No. 021-2004-PCM.</li> </ul>
Ministerial Resolution No. 405-2005/MINSA. Awareness that Regional Health Directorates constitute the only health authority in each Regional Government <sup>155</sup>	May 30, 2005	<ul style="list-style-type: none"> <li>States that Regional Health Directorates constitute the only health authority in each Regional Government.</li> <li>Provides that regional governments approve the administrative organization of health sector dependencies within their realm, in compliance with the guidelines issued by the Ministry of Health.</li> <li>Leaves without effect RM 638 – 2003 SA/DM, delimitation of the Ministry of Health's Health Directorates, Health Networks and Health Micro-networks (34 Health Directorates).</li> </ul>
Ministerial Resolution No. 566-2005-MINSA. Therein approving the guidelines on the adaptation of the organization of Regional Health Directorates in the framework of the	July 22, 2005	<ul style="list-style-type: none"> <li>Provides the general guidelines for adapting the organization of Regional Health Directorates in the framework of the decentralization process.</li> <li>Provides Regional Health Directorate as a line organizational branch of the Social Development Management and Health Networks and hospitals as their de-concentrated bodies.</li> <li>Establishes steps for organizational design, criteria for organic structure definition, hierarchy and positions.</li> </ul>

<sup>152</sup> Congreso de la República: *Aprueban lineamientos para la elaboración y aprobación del Cuadro para Asignación de Personal - CAP de las Entidades de la Administración Pública*. Lima, 17 de junio de 2004.

<sup>153</sup> Congreso de la República: *Ley del Sistema de Acreditación de los Gobiernos Regionales y Locales; Ley N° 28273*. Lima, 8 de julio de 2004.

<sup>154</sup> Congreso de la República: *Reglamento de la Ley N° 28273 - Ley del Sistema de Acreditación de los Gobiernos Regionales y Locales; aprobado por Decreto Supremo N° 080-2004-PCM*. Lima, 15 de noviembre de 2004.

<sup>155</sup> Ministerio de Salud: *Reconocen que las Direcciones Regionales de Salud constituyen la única autoridad de salud en cada Gobierno Regional; Resolución Ministerial N° 405-2005/MINSA*. Lima, 30 de mayo de 2005

Legal Rule	Date of Issue	Main Provisions
decentralization process <sup>156</sup>		<ul style="list-style-type: none"> <li>Establishes organizational model proposals.</li> </ul>
Supreme Decree No. 043-2006-PCM. Guidelines for the elaboration and approval of the Organization and Functions By-law (ROF) from public administration entities <sup>157</sup>	July 21, 2006	<ul style="list-style-type: none"> <li>Provides the general guidelines for every public sector entity (National government, judicial system, public universities, regional and local governments) to follow for the elaboration of the Organization and Functions By-law (ROF).</li> <li>States that for the Regional Governments, the organic structure and the denomination of their bodies follow their organic law and that for their organization the territory focus will prevail.</li> </ul>
Law regulating the transitory regime of regional governments' regional sectorial directorates; Law No. 28926 <sup>158</sup>	December, 2006	<ul style="list-style-type: none"> <li>Provides that regional managements be responsible for regional policies and count on sector bodies as determined by each regional government.</li> <li>States that sector regional directorates are organizational branches dependent on the relevant regional managements and are in charge of specific functions from a regional government's sector realm. In charge of regional directors holding a position of trust.</li> </ul>
Supreme Decree No. 027-2007-PCM <sup>159</sup>	March 22, 2007	<ul style="list-style-type: none"> <li>Provides the need for sector training to regional and local governments in the decentralization process, in order to generate and consolidate convenient management capacity.</li> </ul>
Decentralization Secretariat Resolution No. 003-2007-PCM/SD therein approving Directive No. 001-2007/PCM-SD <sup>160</sup>	May 17, 2007	<ul style="list-style-type: none"> <li>States the signing of management agreements between sectors and regional governments so as to accompany and provide technical assistance to exercise the functions transferred, including cooperation, coordination and collaboration actions.</li> </ul>
Law of the Executive Power; Law No. 29158 <sup>161</sup>	December 20, 2007	<ul style="list-style-type: none"> <li>Provides the basic principles and rules on organization, competencies and functions of the Executive Power as part of the National Government.</li> <li>States the principle of competency, which provides that the Executive Power fulfills its competencies without assuming functions or attributions from other governmental levels, not being able to delegate</li> </ul>

<sup>156</sup> Ministerio de Salud: *Aprueba los Lineamientos para la adecuación de la organización de las Direcciones Regionales de Salud en el marco del proceso de descentralización; Resolución Ministerial N° 566-2005-MINSA*. Lima, 22 de julio 2005

<sup>157</sup> Presidencia del Consejo de Ministros: *Lineamientos para la elaboración y aprobación del reglamento de organización y funciones (ROF) por parte de las entidades de administración pública; Decreto Supremo N° 043-2006-PCM*. Lima, 21 de julio de 2006.

<sup>158</sup> Presidencia del Consejo de Ministros: *Lineamientos para la elaboración y aprobación del reglamento de organización y funciones (ROF) por parte de las entidades de administración pública; Decreto Supremo N° 043-2006-PCM*. Lima, 21 de julio de 2006.

<sup>159</sup> Presidencia del Consejo de Ministros: *Decreto Supremo N° 027-2007- PCM define y establece las Políticas Nacionales de obligatorio cumplimiento para las entidades del Gobierno Nacional*. Lima, 22 de marzo de 2007.

<sup>160</sup> Presidencia del Consejo de Ministros / Secretaría de Descentralización: *Resolución Presidencial N° 003-2007-PCM/SD que aprueba la Directiva N° 001- 2007/PCM-SD "Normas para ejecución de la transferencia del año 2007 a los gobiernos regionales y locales, de las funciones sectoriales incluidas en los Planes de Transferencia"*. Lima, 17 de mayo de 2007.

<sup>161</sup> Congreso de la República: *Ley Orgánica del Poder Ejecutivo; Ley N° 29158*. Lima, 20 de diciembre de 2007.

Legal Rule	Date of Issue	Main Provisions
		or transfer the functions inherent to its own exclusive competencies.
Supreme Decree No. 002-2008-PCM <sup>162</sup>	January 14, 2008	<ul style="list-style-type: none"> <li>Creates the Local and Regional Government Multi-Sector Commission for Capacity-Building on Public Management to strengthen and build capacities for a decentralized public management in the framework of the decentralization process in the country.</li> </ul>
Legislative Decree No. 1026. Provides a special faculty regime for regional and local governments wishing to implement integral institutional modernization processes <sup>163</sup>	June 20, 2008	<ul style="list-style-type: none"> <li>States a faculty regime for regional and local governments' integral institutional modernization, as well as rules they may adopt for this regime.</li> <li>Establishes the rules for the effectiveness of the national government's transfer of human resources to regional and local governments in the framework of the decentralization process.</li> </ul>
Legislative Decree No. 1023. Creates the National Civil Service Authority, governing the Administrative System on Human Resources Management <sup>164</sup>	June 20, 2008	<ul style="list-style-type: none"> <li>Creates the National Civil Service Authority which governs the Administrative System on State Human Resources Management, so as to contribute towards continued improvement of State administration by strengthening civil service.</li> <li>Provides that State entities or companies' Human Resources Offices, or those acting on their behalf, constitute the responsible decentralized level to implement the guidelines, principles, methods, procedures and system techniques.</li> </ul>
Legislative Decree No. 1024. Creates and regulates the public managers group <sup>165</sup>	June 20, 2008	<ul style="list-style-type: none"> <li>Creates and regulates the Public Managers Group, which will be joined by highly-competent professionals, and will be selected in competitive and transparent processes, to be sent to entities from the National Government, Regional Governments and Local Governments requiring their services.</li> </ul>
Legislative Decree No. 1025, therein approving training and performance guidelines for the public sector <sup>166</sup>	June 20, 2008	<ul style="list-style-type: none"> <li>Establishes the training and State personnel evaluation rules, as part of the Administrative System on Human Resources Management.</li> </ul>

<sup>162</sup> Presidencia del Consejo de Ministros: *Decreto Supremo N° 002-2008-PCM, crea la Comisión Multisectorial para el Desarrollo de Capacidades en Gestión Pública de los Gobiernos Regionales y Locales*. Lima, 14 de enero de 2008.

<sup>163</sup> Poder Ejecutivo: *Establece un régimen especial facultativo para los gobiernos regionales y locales que deseen implementar procesos de modernización institucional integral; Decreto Legislativo N° 1026*. Lima, 20 de junio de 2008.

<sup>164</sup> Poder Ejecutivo: *Crea la Autoridad Nacional del Servicio Civil, rectora del Sistema Administrativo de Gestión de Recursos Humanos; Decreto Legislativo N° 1023*. Lima, 20 de junio de 2008.

<sup>165</sup> Poder Ejecutivo: *Crea y regula el cuerpo de gerentes públicos; Decreto Legislativo N° 1024*. Lima, 20 de junio de 2008.

<sup>166</sup> Poder Ejecutivo: *Aprueba normas de capacitación y rendimiento para el sector público; Decreto Legislativo N° 1025*. Lima, 20 de junio de 2008.

Legal Rule	Date of Issue	Main Provisions
Law of the National System of Strategic Planning; DL No. 1088 <sup>167</sup>	June 28, 2008	<ul style="list-style-type: none"> <li>Creates and regulates the organization and operation of the National System of Strategic Planning and the National Strategic Planning Center - CEPLAN, oriented to the development of strategic planning as a technical instrument for governing and managing the harmonious and sustainable development of the country as well as for the strengthening of democratic governability in the framework of the State's constitutional right.</li> </ul>
Supreme Decree No. 047-2009-PCM <sup>168</sup>	July 23, 2009	<ul style="list-style-type: none"> <li>Approves the 2009 Annual Plan for the Transfer of Sectorial Competencies to Regional and Local Governments.</li> <li>Establishes the follow up, strengthening and continuous improvement of the exercise of the competency or function transferred to regional and local governments.</li> <li>Establishes the formulation of the Ministries' Capacity Building Sectorial Plans.</li> <li>Provides the formulation of the Basic Plans for Institutional Capacity Building and Competency and Functions Management, transference subject of Regional and Local Governments.</li> <li>Incorporates the National Civil Service Authority as member of the Multi-Sector Commission for Capacity-Building on Public Management.</li> </ul>
Supreme Decree No. 004-2010-PCM <sup>169</sup>	January 11, 2010	<ul style="list-style-type: none"> <li>Approves the National Plan for Capacity Building on Public Management and Good Governance of Regional and Local Government.</li> </ul>
Supreme Decree No. 009-2010-PCM, approving Leg. Decree Reg. No. 1025 on "Training and Performance Guidelines for the Public Sector" <sup>170</sup>	January 16, 2010	<ul style="list-style-type: none"> <li>Provides the guidelines and procedures applicable for the implementation of training and performance assessment on people working for public entities that are within the Administrative System on Human Resources Management.</li> </ul>

<sup>167</sup> Poder Ejecutivo *Crea y regula el Sistema Nacional de Planeamiento Estratégico y el Centro Nacional de Planeamiento Estratégico*; Decreto Legislativo N° 1088. Lima, 20 de junio de 2008

<sup>168</sup> Presidencia del Consejo de Ministros: *Decreto Supremo N° 047-2009- PCM, aprueba el Plan Anual de Transferencia de Competencias Sectoriales a los Gobiernos Regionales y Locales del año 2009, y otras disposiciones para el desarrollo del proceso de descentralización*. Lima, 23 de julio de 2009.

<sup>169</sup> Presidencia del Consejo de Ministros: *Decreto Supremo N° 004-2010- PCM, aprueba el "Plan Nacional de Desarrollo de Capacidades para la Gestión Pública y Buen Gobierno de los Gobiernos Regionales y Locales"*. Lima, 11 de enero de 2010.

<sup>170</sup> Presidencia del Consejo de Ministros: *Decreto Supremo N° 009-2010- PCM, aprueba el "Reglamento del Decreto Legislativo N° 1025 sobre Normas de Capacitación y Rendimiento para el Sector Público"*. Lima, 16 de enero de 2010.

Legal Rule	Date of Issue	Main Provisions
Supreme Decree No. 115-2010-PCM <sup>171</sup>	December 30, 2010	<ul style="list-style-type: none"> <li>Approves the “2010 Annual Plan for the Transfer of Sectorial Competencies to Regional and Local Governments.”</li> <li>Addresses the Decentralization Secretariat to establish the procedures for the formulation, approval, implementation, monitoring and assessment of Capacity-Building Sectorial, Regional and Local Plans.</li> </ul>
Decentralization Secretariat Resolution No. 154-2011-PCM/SD, therein approving Directive No. 001-2011-PCM/SD:  “General directive for the formulation, approval, implementation, monitoring and evaluation of capacity-building plans” <sup>172</sup>	March 10, 2011	<ul style="list-style-type: none"> <li>States the guidelines and procedures for the formulation, approval, implementation, monitoring and assessment of sectorial, regional and local capacity-building plans as mentioned in Supreme Decree No. 004-2010-PCM, therein approving the National Plan for Capacity Building on Public Management and Good Governance of Regional and Local Government, in Article 8 of Supreme Decree No. 047-2009-PCM, approving the 2009 Annual Plan for the Transfer of Sectorial Competencies to Regional and Local Governments, in compliance with Item 7.5 of Article 7 of Supreme Decree No.115-2010-PCM approving the 2010 Annual Plan for the Transfer of Sectorial Competencies to Regional and Local Governments.</li> </ul>
Ministerial Resolution No. 184-2011-MINSA <sup>173</sup>	March 15, 2011	<ul style="list-style-type: none"> <li>Approves the 2010-2014 Agreed Sectorial and Decentralized Plan for Health Capacity Building – PLANSALUD</li> </ul>
Executive Presidency Resolution No. 041-2011-SERVIR/PE, therein approving Directive No. 001-2011-SERVIR-GDCR "Directive for the elaboration of the Capacity-Building Plan for State-Level People"	March 21, 2011	<ul style="list-style-type: none"> <li>States the guidelines for the elaboration of capacity-building plans for people.</li> </ul>

<sup>171</sup> Presidencia del Consejo de Ministros: *Decreto Supremo N° 115-2010- PCM aprueba aprueba la Directiva N° 001-2011-PCM/SD: aprueba la Directiva N° 001-2011-PCM/SD: “Directiva general para la formulación, aprobación, implementación, monitoreo y evaluación de los planes de desarrollo de capacidades”*. Lima, 30 de diciembre 2010.

<sup>172</sup> Presidencia del Consejo de Ministros: *Resolución de Secretaría de Descentralización N° 1544-2011- PCM/SD*, aprueba el “Plan Nacional de Desarrollo de Capacidades para la Gestión Pública y Buen Gobierno de los Gobiernos Regionales y Locales”. Lima, 10 de marzo de 2011.

<sup>173</sup> Ministerio de Salud: *Resolución Ministerial N° 184-2011-MINSA*, aprueba el “Plan Sectorial Concertado y Descentralizado para el Desarrollo de Capacidades en Salud 2010 -2014 –PLANSALUD”. Lima, 15 de marzo de 2011.

### 3. Processes for Responsibility Transference in Health

Responsibilities transference is the public policy component of the decentralization process, addressed to the transference of governmental competencies and functions among national, regional, provincial and district levels. Its aim is to achieve a decentralized State for the exercise of the governmental stewardship and the management of the goods and services rendered by the State to the citizenship. The set of policies involved in this component comprises several specific policies:

- The delimitation of the competencies and the distribution of functions among the different governmental levels.
- The transference of the ownership of competencies and functions corresponding to each governmental level.
- The transference of human, financial and material resources associated to the transferred functions for its full exercise.
- The transference of the operational instruments required for the exercise of those functions that should be executed together by different governmental levels, in consecutive or simultaneous stages of the same process.

Thus, the essence of decentralization is to recognize that the government functions of the unitary State must be assumed by different governmental levels in an agreed and complementary manner. Therefore, the specificity of this process is the extension of the governmental functions in the decentralized levels of the State.

#### 3.1 Delimitation of Health Competencies

In the health sector, the transference of responsibilities must rise from designing a new institutional ordering. Thus, a fundamental policy must be to have a clear and coherent design of the **delimitation of competencies** and the **distribution of functions** among the different governmental levels, which requires being systematically elaborated and employing an integral focus that takes into account the multiple institutional interactions of political, administrative and legal nature.<sup>174</sup> This arrangement of distribution of governmental competencies is complex, as it could simultaneously happen that a governmental level may operate consequently at another level for a specific function while operating autonomously for other functions. However, such map of competencies is essential insofar as it must specify the responsibility, faculty or exclusive attribution of every level of government for the exercise of shared competencies. It is necessary to keep watch over the coherence of the purposes and to maintain certain homogeneity in the processes, trying to avoid institutional fragmentation, bureaucratic rigidity and evasion of responsibilities. On the other hand, it is important to take into consideration that in heterogeneous countries, management capabilities of regional and local levels are different. In consequence, the scheme of distribution of competencies must be conceptualized as an open and flexible system, which allows to be updated by means of consensus of the actors. In a decentralized system, the harmonic functioning among the different governmental levels requires a balance among the

---

<sup>174</sup> World Bank: *Decentralization, rethinking government*. In: *World Development Report 1999/2000*; Chapter 5. 2000.

exclusive functions of each one in its territory and to be shared with other agents, where everyone seeks the achievement of common objectives by means of agreements.<sup>175</sup> In order to achieve such attributes, it is necessary to specify some elements that should be incorporated in the methodology to be employed in formulating the proposals delimitation of competencies matrices and distribution of sectorial functions matrices<sup>176</sup>.

1. Identification of the subjects of sectorial competency; that is, the objects, subjects or fields of the society over which the sectorial governmental management will exert certain competencies.
2. Identification and definition of the essential<sup>177</sup>, processes<sup>178</sup> of the sector; that is, governmental responsibilities and action directly exerted over its subject matter or competency realm and which are essential for the fulfillment of the purpose of each sector. This includes the distinction of governance or sectorial processes and policy processes from those of provision of services, combining (whenever relevant) one of this basic essential functions of provision of services or of regulation with each sectorial competency subject. The purpose of establishing a definition is to explicitly and precisely delimit the realm of each one of the identified essential sectorial processes, trying to set up with the best possible clarity the limits amongst these and seeking to avoid the duplicity of certain functions.
3. Analysis of the specific essential processes regarding the base of standard flows which distinguish governance or sectorial processes and policy processes<sup>179</sup> from those of provision of goods or services<sup>180</sup>. The basic methodology to be used is the analysis of processes by disaggregating them in their key functions<sup>181</sup> within said management process, based on a determined logical sequence<sup>182</sup>.

---

<sup>175</sup> Guimaraes, Luisa (2001): Op. cit.

<sup>176</sup> Presidencia del Consejo de Ministros / Secretaría de Gestión Pública: *Guía metodológica complementaria para el análisis de las matrices de delimitación de competencias y distribución de funciones sectoriales*. Lima, 2009.

<sup>177</sup> *Essential Process*: Corresponds to the management processes related to the fundamental functions of the entity; that is, those directly exercised over their competency realm and essential for the fulfillment of their purpose, resulting in the provision of services to the population or the management and promotion of a determined social or economic activity.

<sup>178</sup> *Process*: Set of activities related among them, that develop in a series of sequential stages and that transform raw material adding value, in order to deliver a specific result, good or service to a recipient, external or internal user, optimizing the resources of the organization.

<sup>179</sup> *Sectorial Management or Governance*: Process aimed to govern the development of inter-sector activities and activities of its competency realm (operation of public and private services; production, marketing and consumption of goods, etc.), in order to guarantee on behalf of the State their efficiency, safety and quality, as well as the rights of citizens in different matters, in coordination with the other relevant bodies.

<sup>180</sup> *Organization and Provision of Public Goods or Services*: Process aimed to manage and lead the services or production of public services in the object of their competency and guide their planning, organization, management and control for the achievement of public health, social and economic objectives.

<sup>181</sup> *Key Function*: sub process or group of specific and similar activities which are executed for the achievement of some goal, transforming inputs in some partial result inside the process.

<sup>182</sup> Harrington, H.: *Mejoramiento de los procesos de una empresa*. Mc Graw-Hill. 1986.

4. Distribution of specific functions at each government level in each process flow, identifying the specific faculties or responsibilities for exercising key functions within the different governmental levels according to the role that corresponds to each one and to the provision stipulated in the general legal framework of the decentralization process, in its specific organic laws and in the performed transference plans.
5. Identification of other entities intervening in the processes, establishing the areas of intersection among specific functions identified in each essential process of Entities of the State, other than those forming part of the Sector.

### 3.1.1 Delimitation of Competencies in the 2002 - 2006 Period

As it was previously mentioned, every decentralization process involves a reordering of competencies and functions among the different governmental levels, thus requiring a legal framework which specifies this framework of competencies and functions, and which allows the development of the different governmental levels under precise and coherent rules, of duly promulgation and stable in their expiration. However, the analysis of the legal framework progress allows to conclude that it was inappropriate, especially the definition of the functions of the National Executive Power. In such sense, the law of constitutional amendment over decentralization did not specify them, while the decentralization bases law only established that the national government has, as exclusive function, the design of national and sectorial policies and that its shared competencies must be ruled by the Executive Power Organic Law and the organic laws of its different sectors<sup>183</sup>. Thus, in consequence of the delay of the Executive Power Organic Law (LOPE) and of the organic laws of the ministries, this framework of governmental competencies is still incomplete after almost a decade since the start of the process.

On the other hand, the definition of the functions of regional and local governments is unclear. For example, out of 16 functions in health assigned to regional governments, one is a task (to participate in the Coordinated and Decentralized National Health System), another one is more linked to an objective (to execute, in coordination with local governments of the region, effective actions which contribute to rise nutritional levels of the population in the region), and others are not univocal and are prone to duplicity with other entities (to promote and preserve the environmental health of the region)<sup>184</sup>. Likewise, the organic law of municipalities assigns to it the function of “managing primary health care as well as building and equipping health posts, first aid kits and health centers”<sup>185</sup>, without much precision, and how their relations with regional governments would be to this regard. It must be further mentioned that the same law assigns to municipalities those exclusive functions related to basic healthiness and sanitation, several of which were carried out by health directorates despite the fact that they had already been established in the law of municipalities of 1984<sup>186</sup>. Facing this situation, the executive power of the national government and the National Council for Decentralization (CND) did not specify in their agenda the competencies

---

<sup>183</sup> Congreso de la República: *Ley de bases de la descentralización*. Op. cit. Artículos 26 y 27.

<sup>184</sup> Congreso de la República: *Ley Orgánica de los Gobiernos Regionales*. Op. cit. Artículo 49.

<sup>185</sup> Congreso de la República: *Ley orgánica de municipalidades*. Op. cit. Artículo 80.

<sup>186</sup> Congreso de la República: *Ley orgánica de municipalidades*; *Ley N° 23853*. Lima, 1984.

and the distribution of functions among the three governmental levels, wherein such objective of the CND's operational plan did not appear<sup>187, 188</sup>.

As it was already mentioned in the initial situation of the health sector, at the beginning of the governmental period of Alejandro Toledo, the health ministerial management of Dr. Luís Solari (July 2001 – January 2002) was reluctant to the decentralization process, wherein the legal framework set aside the health sector to a fourth and last stage of the decentralization process<sup>189</sup>, and which only in January 2004 would start the transferences of health functions<sup>190</sup> when the minister started managing the Presidency of the Council of Ministers (PCM). Such situation of resistance to the process was kept during the ministerial management of Dr. Fernando Carbone (January 2002 – June 2003),<sup>191, 192</sup> while the following minister Dr. Álvaro Vidal (July 2003 – February 2004) did not actively promote the process despite the fact that he should have constituted the transference commission in MINSA<sup>193</sup> and elaborate the health transference plan for 2004<sup>194</sup>.

The situation in the health sector significantly changed when Dr. Pilar Mazzetti (February 16, 2004 – July 2006) assumed the ministerial management. She actively fostered the process in health from the beginning and decisively contributed to specify the health functions of the incomplete legal framework by means of efforts for delimitating its competencies and functions. In such sense, there have been several initiatives in the health sector to continue in a better development:

### **1. 2004 Road Map for Health Sector Decentralization**

In this way, at the time when Dr. Mazzetti started her management, MINSA did not count with a transference commission in operation or a health transference plan. Thus, the first provisions included the designation of a ministerial advisor in health decentralization (Dr. Eva Guerrero), the constitution of an office of decentralization and the formation of a technical team to prepare a matrix of functions since March 2004, which would be the basis to formulate the 2004-2006 Transference Plan and the Road Map defining the transference process.

---

<sup>187</sup> Bardález, Carlos: *Avances en la formulación de un marco legal de descentralización de redes y servicios*. Lima, 2003. Op. cit.

<sup>188</sup> Consejo Nacional de Descentralización / Consejo Directivo: *Plan Nacional de Descentralización 2004 – 2006*. Lima, 2004.

<sup>189</sup> Congreso de la República: *Ley de bases de la descentralización*. Op. cit. Segunda disposición transitoria.

<sup>190</sup> Congreso de la República: *Ley N° 27902, ley que modifica la Ley Orgánica de los Gobiernos Regionales N° 27687*. Op. cit. Cuarta disposición transitoria.

<sup>191</sup> Bardález, Carlos: *Avances en la formulación de un marco legal de descentralización de redes y servicios*. Lima, 2003. Op. cit.

<sup>192</sup> Távara, Gerardo y Márquez, Jaime: *Sistematización del proceso de descentralización del sector salud*. Promoviendo alianzas y estrategias, Abt Associates Inc. Lima, marzo de 2009

<sup>193</sup> Guerra-García, G.; Arca, J. M.; Arguedas, C.; Minaya, V.: *Hoja de ruta de la descentralización del sector salud*. Lima, noviembre de 2004.

<sup>194</sup> Ugarte, O. y Bardález, C.: *Proceso de descentralización en salud*. Promoviendo alianzas y estrategias, Abt Associates Inc. Lima, Lima, 2006.

To the extent that at that period the health sector was ruled by regulations prior to the decentralizing and gradient legal framework, the main limitation was that this one did not describe the operation of MINSA nor the interfaces among central headquarters, decentralized public organisms, health directorates, health networks and micro-networks and local governments. As a result, MINSA based its proposal in a “*Current Operational Matrix*” describing the distribution of specific competencies that were in operation among the different instances of the sector, identifying 14 processes<sup>195</sup>, 66 sub-processes and 234 tasks regarding sectorial regulations in force at that time. The distribution of competencies of this proposal was adapted to decentralization using the “*Matrix of the Legal Framework in Force*”, performing an extensive interpretation of the decentralizing regulations in a structure of 10 processes<sup>196</sup>. Finally, a “*Distribution of Competency Matrix*” was prepared, adapting the operational matrix to the new legal framework described in the second matrix, which resulted in the 14 processes and 66 sub-processes of the first matrix but with a comprehensive identification of tasks and functions for each governmental level, reaching several hundreds of regional faculties. This national proposal was completed in November 2004 and was mainly prepared by the respective technical team.<sup>197</sup>

The analysis of such proposal allows drawing the following conclusions:

- The proposal was based on the organization and regulations of the health sector prior to the decentralization process, fitting them to the legal framework of decentralization. In such sense, the proposal is essentially built over the description of the 14 processes and 66 sub-processes established in prior regulations<sup>198</sup>, with its corresponding limitations of origin. Consequently, we may indeed identify competency realms among sectorial processes in some cases (environmental health, information regarding health, financing) or institutional arrangement (Comprehensive Health Insurance), while in others the processes are incomplete (computer science development, human resources development). These limitations have their origin in the non-definition of the sectorial competency realms of the MINSA law, which are replaced by “*competencies of MINSA’s sectorial governance*” (actually, general functions of MINSA)<sup>199</sup>.
- On the other hand, the identified sectorial processes had a close coincidence with the organic structure of MINSA, defined in the MINSA law and expressed as sectorial and institutional processes in its regulation.<sup>200</sup>

---

<sup>195</sup> Promotion of health; environmental health; health protection, recovery and rehabilitation; medication control; prevention of epidemics, emergencies and disasters; integral health insurance; planning, organization, information on health; data processing development; investment in health; financing, development of Human Resources and Integrated Logistics.

<sup>196</sup> Promotion of health; environmental health; health protection, recovery and rehabilitation; medication, raw materials and drugs control; prevention and control of epidemics, emergencies and disasters; planning, organization, information on health; investment in health and development of Human Resources.

<sup>197</sup> Guerra-García, G.; Arca, J. M.; Arguedas, C.; Minaya, V.: *Hoja de ruta de la descentralización del sector salud*. Lima, noviembre de 2004.

<sup>198</sup> Poder ejecutivo: *Reglamento de la Ley N° 27657 - Ley del Ministerio de Salud*. Lima, 2002. Op. cit.

<sup>199</sup> Congreso de la República: *Ley N° 27657; Ley del Ministerio de Salud*. Lima, 2002. Artículos 3.

<sup>200</sup> *Ibíd.*

- Likewise, since it is based on such organizational regulations, the proposal picks up the analysis of the sub-processes it supports, determining a very comprehensive description of several hundreds of functions, which in several of them correspond to tasks.
- For all the above mentioned, the proposal is not based on what *the sector should do* but rather on *what MINSA did* in the period prior to the decentralization process based on regulations. Due to this, the management or regulation of the investigation in health is not identified as a process.
- Finally, in the formulation of this proposal, the participation of the different MINSA directorates was limited.

## 2. Concerted Map of Health Competencies (MCC Salud)

In parallel, a similar process was developed by several regional governments with the technical assistance of the USAID Partners for Health Reformplus (PHRplus) project between February and November 2004, with the purpose of specifying the distribution of responsibilities among the different governmental levels in the health decentralization process. Initially, between February and April 2004 PHRplus prepared the technical proposal of a Map of health competencies, supported in the legal framework of decentralization and with the opinion of national experts. This job was put at the disposal of the main actors<sup>201</sup> for its corresponding revision in the regions of La Libertad, Lambayeque, San Martín and Pucallpa between April and September 2004. Subsequently, the regional proposal of MCC Salud was assumed by 22 general health directors of the country in a meeting performed on November 24-25, 2004, organized by the Northern Macro Region, as a unified proposal called "*Regional Contributions to the Road Map of Health Decentralization*". This integrated the contributions of the four regions where it was revised and aimed to be used as a contribution in the negotiation processes of the competency transference plans between MINSA and regional governments.<sup>202, 203</sup>

The preparation of MCC Salud was based in the methodology of *process analysis*, each one being understood as a group of key functions comprising a determined logical sequence, transforming raw materials or needs (input) of the users of an organization into products and services (output), with an added value in terms of results<sup>204</sup>. The process identification was done based on the sequential identification of: a) the *purpose* of the health sector; b) its *field of competency* with its *objects or subjects of competencies*; c) its *sectorial public management processes*; d) the *sectorial management process analysis*, identifying its *key functions*; and, e) finally carrying out the *distribution of specific faculties for the different decision units of health management*. For this, such analysis took as reference what the State must develop in its different levels, considering everything it *should do* and not being restricted only to what it is *currently doing*. This included, by

<sup>201</sup> Representatives of regional governments, regional health directorates, municipalities, civil society organizations, health networks and hospitals.

<sup>202</sup> Bardález, C. y Ugarte, Ó.: *Mapa concertado de competencias y proceso de transferencia de funciones en la descentralización del sector salud*. The Partners for Health Reformplus Project, Abt Associates. Lima, febrero de 2005.

<sup>203</sup> Bardález, C.: *Guía Metodológica del Mapa Concertado de Competencias en Salud*. Promoviendo alianzas y estrategias, Abt Associates Inc. Lima, julio de 2006.

<sup>204</sup> Harrington, H.: *Mejoramiento de los procesos de una empresa*. Mc Graw-Hill. 1986.

the way, the differentiation of processes for the *provision of public services* from those of *sectorial regulation and enforcement*, proper of any governmental entity, in the sense that the State must not only provide public services but mainly *govern*, enforcing the fulfillment of the laws. As a product, 19 processes<sup>205</sup> and 138 regional faculties<sup>206</sup> were identified.

The analysis of such proposal allows drawing the following conclusions:

- The proposal was supported in the legal framework of decentralization and an identification of sectorial processes, which was not exclusively restricted to previous organization and regulations of the health sector. In this way there was better accuracy regarding processes, distinguishing those for the *provision of public services* from those for *sectorial regulation and enforcement*.
- Since it is based on process analysis, it results in a more delimited and hierarchically homogeneous number of functions.
- Finally, the formulation of this proposal counted with an advice-based participative process among regional actors.

### 3. *Matrix of Regional Functions Concerted between MINSA and Regions*

After completing the “Road Map for Health Sector Decentralization” proposal, MINSA organized the “*I National Workshop on Decentralization*”, carried out on December 9-10, 2004, where it was presented for its revision with regional governments and their DIRESAs, as well as with the different general directorates of MINSA, thus opening a process of negotiation aimed at coming together with a concerted proposal of competency matrix for regional governments. The object of such negotiation was exclusively the definition of regional functions, and not national or local functions, and it implied coming together in an integrated version over the basis of both proposals: One from MINSA and the other one from the regions. The product of this negotiation was a preliminary version of the matrix with 204 regional faculties, significantly simplifying the version proposed by MINSA and incorporating important regional contributions and contributions from the general directorates and offices of MINSA, among which was the incorporation of the management process of health investigation. This proposal was submitted by MINSA to CND.<sup>207, 208</sup>

<sup>205</sup> Sectorial regulation and enforcement of persons’ health, Sectorial regulation and enforcement of Environmental Health, Sectorial regulation and enforcement of medicines, Sectorial regulation and enforcement of human resources, Organization and management of persons’ health services, Organization and management of environmental and occupational health services, Promotion, protection and guarantee of citizens’ participation, Supply management of medicines in public health services, Logistic and supply management, Financial management, Health insurance management in public health services, Investment management, Institutional management of human resources, Health information management, Health research management, Health policies management, Sectorial and institutional strategic planning, operative planning, Institutional organization.

<sup>206</sup> Bardález, C. y Ugarte, Ó.: *Mapa concertado de competencias y proceso de transferencia de funciones en la descentralización del sector salud*. Lima, febrero de 2005. Op. cit.

<sup>207</sup> *Ibídem*.

<sup>208</sup> Ministerio de Salud / Oficina de Descentralización: *Hoja de ruta para la descentralización de la función salud; actualización, avances y agenda pendiente*. Lima, julio de 2006.

Subsequently, between January 10 and 27, 2005, MINSA held a total of thirteen technical meetings with general directorates and offices, programs and projects of MINSA responsible for the processes, in order to revise the regional functions proposal established for each process, correcting its writing, incorporating missing functions, consolidating tasks in functions and performing the consistency among functions. The results were taken to consultation for their approval to the “*IV National Meeting between the Ministry of Health and Regional Governments; Building Consensus for the Health Agenda*”, held in Lima on February 22 and 23, 2005 and organized by MINSA, with the participation of regional governments of the country. These agreements constituted the national proposal for health decentralization, consisting of 125 regional faculties, arranged between both governmental levels and being quite solid. It was further submitted by MINSA to CND by the end of the month of February 2005, being approved as a Middle-term health transference plan<sup>209, 210, 211</sup>.

#### **4. Health Competencies Differentiated by Governmental Levels, 2006**

After MINSA and the regional governments reached an agreement regarding regional health functions, MINSA adjusted its original functions matrix proposal, restating the attributions at national and local level besides including the disaggregation of the faculties in tasks. This product was elaborated with the different general directorates and offices of MINSA, where the consultation with the regional and local governments remained pending. It was incorporated in the 2006 new version of the “*Road Map for Health Function Decentralization; Pending Update, Advances and Agenda*.”<sup>212</sup>

##### **3.1.2 Delimitation of Competencies in the 2006-2011 Period**

In the 2006-2011 period there were also several initiatives aimed at specify the framework of competencies and functions among the three governmental levels, which were performed in different ministerial managements, although without the necessary continuity:

##### **1. Competencies Map of Local Governments, 2006**

In the framework of the “*decentralization shock*”, at the beginning of Dr. Alan García’s new ministerial management, it was established that as of January 1, 2007 the transference of primary health care management to provincial and district municipalities had to begin, by means of the start-up of pilot plans<sup>213</sup>. In this context, it was necessary to specify the functions of local governments. Therefore, MINSA organized the “*Workshop of Experts on Local Health Decentralization: Health Competencies Matrix*”, with the attendance of MINSA officers, provincial and district municipalities, and professional experts, carried out on November 27 and 28, 2006. The

<sup>209</sup> Consejo Nacional de Descentralización: *Plan de Transferencia Sectorial del Quinquenio 2005 – 2009*. Resolución Presidencial N° 026-CND-P-2005. Lima, 29 de marzo de 2005.

<sup>210</sup> Bardález, C.: *Guía Metodológica del Mapa Concertado de Competencias en Salud*. Promoviendo alianzas y estrategias, Abt Associates Inc. Lima, julio de 2006.

<sup>211</sup> Ministerio de Salud / Oficina de Descentralización: *Hoja de ruta para la descentralización de la función salud; actualización, avances y agenda pendiente*. Lima, julio de 2006.

<sup>212</sup> *Ibíd.*

<sup>213</sup> Poder Ejecutivo: *Establecen disposiciones relativas al proceso de transferencia de la gestión de la atención primaria de salud a las municipalidades provinciales y distritales*. Decreto Supremo 077-2006-PCM. Lima, 30 de octubre de 2006.

identification of such functions responded to the conclusions of two national meetings between MINSA and the majors of different regions of the country, held in October and December 2006: a) the definition of the subject of transference to local governments was a condition to start the corresponding decentralization process; b) The process should be gradual starting on 2007, after the strengthening of regional governments from 2006. However, the products of said workshop were not made official and the regulations regarding pilot plans only stated that the matrix of functions to be transferred should be performed following a process similar to the one performed for identifying regional functions<sup>214</sup> or that this definition was necessary during the execution phase of functions transferences of pilot projects<sup>215</sup>, or that it should be performed during the same phase by MINSA with regional and local governments<sup>216</sup>.

## **2. Delimitation of Competencies and Distribution of Functions Matrices – MINSA, 2008**

With the approval of the Executive Power Organic Law in December 2007, the ministries sharing competencies with other governmental levels should elaborate their organization and functions law proposals in a term of six months<sup>217</sup>. In this context, the coordination and technical assistance to the ministries for such task was addressed to the Secretariat of Public Management of the PCM.

Thus, in February 2008, MINSA issued a ministerial resolution forming a commission to formulate its LOF<sup>218</sup> proposal, constituted by the General Secretariat, the Vice-Ministerial Office and Strategic Planning, Legal Advice and Administration general offices. In July 2008, PCM submitted to the Congress of the Republic the LOF project by MINSA<sup>219</sup>. Such proposal did not align with the ongoing decentralization process as it did not clearly specify the competency realms of the sector, and neither clearly distinguished national governance and shared functions in relation to the functions already transferred to regional governments.

On the other side, to retrospectively frame the formulation of the LOF projects of the different ministries with the decentralization, the PCM's Secretariat of Public Management issued a directive in June 2008 establishing the need and regulating the formulation of delimitation of competencies and distribution of functions matrices as well as their link with the organization and functions bills of the respective ministries. On June 11, it had organized an orientation workshop for the elaboration of such matrices with the ministries. The following was necessary for the elaboration of these matrices:<sup>220</sup>

<sup>214</sup> Ministerio de Salud: *Documento Técnico “Descentralización de la Función Salud al Nivel Local; Los Proyectos Piloto” Resolución Ministerial N° 042-2007-MINSA*. Lima, enero de 2007.

<sup>215</sup> Ministerio de Salud: “Documento técnico: *Desarrollo de la función salud en los gobiernos locales*”. *Resolución Ministerial N° 366-2007-MINSA*. Lima, 5 de mayo del 2007.

<sup>216</sup> Ministerio de Salud: *Guía de implementación de los proyectos pilotos de descentralización en salud a los gobiernos locales; Resolución Ministerial N° 614-2007-MINSA*. Lima, 1 de agosto del 2007.

<sup>217</sup> Congreso de la República: *Ley Orgánica del Poder Ejecutivo*. 2007. Op. cit. Primera disposición transitoria.

<sup>218</sup> Ministerio de Salud: *Conforman grupo de trabajo encargado de la implementación de la LOPE en el Ministerio de Salud; Resolución Ministerial N° 067-2008/MINSA*. Lima, 8 de febrero de 2008.

<sup>219</sup> Poder Ejecutivo: *Proyecto de Ley de Organización y Funciones del Ministerio de Salud. Comunicación al Congreso de la República*. Lima, 25 de Julio de 2008.

<sup>220</sup> Presidencia del Consejo de Ministros: *Resolución Ministerial que aprueba la elaboración de las Matrices de delimitación de competencias y distribución de funciones y los ante proyectos de LOF de los ministerios que tienen*

- First, it must specify the competency realms of each ministry to further identify the essential processes for each competency (provision of services or enforcement and promotion of certain social or economic activity related to their subjects of competency).
- Then, it had to identify the attributions of: a) rules, regulations and policies; b) planning; c) administration and execution; and, d) monitoring and assessment. To further clearly delimit the responsibilities among each ministry, its public bodies and regional and local governments.
- The matrices must be consulted with regional and local governments.
- They should be the basis for the formulation of LOF projects; however, it established that the matrices would be approved 60 days following the promulgation of the respective LOF by means of a supreme decree.

In the framework of this regulation, the MINSA commission identified nine essential processes and formulated the respective matrices, submitting them to consultation with the PCM's Secretariat of Public Management and representatives of the Constitutional Court, Ombudsman and the PCM's Secretariat for Decentralization on June 22, 2008; as well as the different MINSA general directorates and offices on June 26-27, 2008. On the other hand, the commission also elaborated a new LOF proposal, besides the matrices proposals, which were submitted to PCM in September 2008<sup>221</sup>. The analysis of the matrices prepared by MINSA enables to conclude limitations when applying the corresponding PCM regulations<sup>222</sup>:

- It does not specify the competency realms of the health sector<sup>223</sup> nor does it distinguish the sectorial enforcement processes from those of the provision of services, although it makes efforts to identify specific competencies in the national realm for each one of the processes identified.
- It includes an essential process additional to the eight ones previously identified by MINSA: the one on "Development of infrastructure, equipment in health care centers and medical support services".
- In some cases, it includes administrative support functions<sup>224</sup> that do not correspond to essential processes.
- It restricts the political autonomy of regional governments by exclusively assigning them functions of adaptation and implementation of national policies.

---

*a su cargo competencias exclusiva y compartidas; Resolución Ministerial N° 188-2008-PCM que aprueba la Directiva N° 003-2008-PCM/SGP. Lima, 13 de junio de 2008.*

<sup>221</sup> Ayuda memoria de la Oficina General de Planificación Estratégica del MINSA, marzo de 2009.

<sup>222</sup> Ministerio de Salud: *Matrices de delimitación de competencias y distribución de funciones del sector salud*. Lima, septiembre de 2008,

<sup>223</sup> Established that the competency realm of the health sector was *health*, that is, a tautology; whereas what had to be specified were the competency realms within the health sector.

<sup>224</sup> In the processes of development of Human Resources in health; development of infrastructure, equipment in health facilities and support medical services; information for health.

- Although it addresses as regional functions those already transferred, in some cases it assigns the same functions to the national government, generating duplicity.
- It identifies the national functions in regards to regional functions and not to the inherent nature of national governing body, resulting in limitations on its sectorial regulation and enforcement functions.
- It restricts the functions of local governments already defined in the law of municipalities. In other cases, it assigns functions at national level or regional functions exclusive of municipalities.

In this context, the PCM's Secretariat of Public Management organized a set of consultation workshops with regional governments between September 2008 and January 2009, aimed to receiving contributions and observations from regional governments to the different sectorial matrices. However, the advances in this validation process were very trifling, as it may be noted in the health sector in table No. 4. Besides, it was noted that the Decentralization Secretariat identified that the functions stated for regional governments did not always correspond to the functions already transferred. Thus, consultation workshops were cancelled and it was agreed with the SGP-PCM to perform a "validation" process of the matrices.

**Table No. 4: Revision process of the delimitation of competencies and distribution of health functions matrices, February 2009**

Regional Governments	Revised Processes
Ancash	-----
Arequipa, Puno	-----
Callao	2 processes
Cuzco, Madre de Dios, Apurímac	1 process
San Martín	2 processes
Huánuco, Pasco	3 processes
Ica, Ayacucho	2 processes
Loreto	2 processes
Junín, Huancavelica	5 processes
La Libertad, Cajamarca	2 processes
Lima Provinces	5 processes
Piura	2 processes
Piura, Tumbes	2 processes

3. Source: PCM: Cards of Consultation Reports with Regions by MINSA.

#### 4. Competencies Delimitation and Functions Distribution Matrices – PCM, 2009

In this context, in February 2009, the PCM's Secretariats of Public Management and Decentralization agreed to develop a joint strategy with the purpose of aligning the LOF projects of the ministries with shared competencies, with a clear delimitation of competencies among the three governmental levels, consigned in the corresponding sectorial matrices. This strategy included: Improving the matrices formulation methodology, specifying the procedures already established in prior regulations<sup>225</sup>, issuing complementary regulations, performing the analysis of consistency of the matrices prepared by the different ministries with sectorial specialists and the revision of both secretariats, revising these proposals with the respective ministries, simultaneously consulting the matrices in sectorial workshops with the group of governments and representatives of the associations of municipalities, leaving behind the scheme of multiple consultation meetings, approving the matrices. Thus, PCM intended to solve the problem which appeared with the elaboration of the different sectorial LOF projects that were not supported in the matrices and the event which happened in 2008 of its formulation prior to formulating such matrices.<sup>226</sup>

In such sense, the PCM's Secretariat of Public Management prepared a new methodological document for the elaboration of matrices, with the technical assistance of the USAID / Health Systems 20/20 project, systematizing the experience in the elaboration of functions matrices and specifying a series of methodological steps, based on the stipulated regulations directive No. 003-2008-PCM/SGP of "Guidelines for the elaboration of the competencies and functions matrix and of the organization and functions bills of the ministries in charge of exclusive and shared competencies", approved by Ministerial Resolution No. 188-2008-PCM. This methodology detailed the following:<sup>227</sup>

- It specified the methodological procedures for the identification of the sectorial competency subjects and essential processes of state sectors.
- It differentiated the essential processes of *sectorial governance or enforcement and of policies* from those of *provision of public services*.
- It detailed methodological procedures for the analysis of the essential processes, suggesting standard flows in function of the different nature of the processes of *sectorial governance or enforcement and of policies* from those of *provision of public services*.

Likewise, it selected sectorial theme specialists with the support of the international cooperation (Program PRODER, GTZ, USAID-HS 20/20, USAID-APRENDES and the BID-PMDE Program). On the other hand, PCM determined by means of Supreme Decree No. 049-2009-PCM<sup>228</sup>, the mandatory approval of the delimitation of competencies and distribution of functions matrices of

<sup>225</sup> Resolución Ministerial N° 188-2008-PCM que aprueba la Directiva N° 003-2008-PCM/SGP.

<sup>226</sup> Presidencia del Consejo de Ministros / Secretaría de Gestión Pública: *Informe de Reunión de trabajo para la presentación de avances en el proceso de validación de las matrices y clarificación de la estrategia a futuro para la culminación de este proceso*. Lima, 7 de julio de 2009.

<sup>227</sup> Presidencia del Consejo de Ministros / Secretaría de Gestión Pública: *Guía metodológica complementaria para el análisis de las matrices de delimitación de competencias y distribución de funciones sectoriales*. Lima, julio de 2009.

<sup>228</sup> Poder Ejecutivo: *Decreto supremo que dicta disposiciones para la aprobación de las matrices de delimitación de competencias y distribución de funciones de los ministerios que tienen a su cargo competencias exclusiva y compartidas; Decreto Supremo N° 049-2009-PCM*. Lima, 23 de julio de 2009.

each governmental level so as to clearly establish the competencies and functions of each governmental level. In the specific case of the health sector, the SGP established the following schedule to be held between March and September 2009:<sup>229, 230</sup>

- Elaboration of the technical proposal of health matrices.
- Revision of the technical proposal of matrices by PCM.
- Negotiation and revision of the technical proposal of matrices PCM/MINSA/Sectorial health specialist.
- National, regional and local workshop on validation of the of health matrices proposal.
- Systematization of suggestions from the national workshop on validation of matrices.
- Final adjustment of sectorial matrices of health functions.
- Elaboration of the technical LOF proposal by MINSA.
- Final revision of the LOF proposal by MINSA performed by PCM/MINSA.

The technical proposal of health matrices was revised by the PCM's Secretariats of Public Management and of Decentralization, concluding in June 2009<sup>231</sup>, to be further submitted to MINSA according to the established schedule. However, PCM did not get a positive response from MINSA so as to enter into the stage of negotiation and revision of the technical proposal of matrices with PCM, despite the meetings held with the Minister of Health. MINSA officers showed resistance to perform a more precise identification of the competency realms and, above all, to distinguish the essential processes according to their nature of *sectorial governance or enforcement and of policies* or of *provision of public services*, as well as to establish a structure of essential processes different from the organic structure of the ministry. This resistance was not exclusive to the health sector, but it was rather shared also with other ministries, especially with those holding an important role of provision of public services. This distinction implied to clearly identify the processes of provision of public services, which consequently had to be transferred to regional and local governments, as well as of sectorial enforcement, where there was a very incipient development after a decade of state deregulation<sup>232</sup>.

Facing these difficulties with the sectors, in November 2009 the SGP of PCM agreed with the representatives of the National Assembly of Regional Governments (ANGR), the Municipality Association of Peru (AMPE) and the Rural Municipal Network of Peru (REMURPE) to constitute an intergovernmental working table to revise the sectors' matrices. Besides, in March 2009, SGP-PCM submitted to ANGR, AMPE and REMURPE a schedule establishing the approximate dates for the delivery of matrices and the performance of consultation meetings. This schedule was only fulfilled

---

<sup>229</sup> *Ibíd.*

<sup>230</sup> Presidencia del Consejo de Ministros / Secretaría de Gestión Pública: *Informe de Reunión de trabajo para la presentación de avances en el proceso de validación de las matrices y clarificación de la estrategia a futuro para la culminación de este proceso*. Lima, 7 de julio de 2009.

<sup>231</sup> Comunicación del proyecto USAID Health Systems 20/20 a la Secretaría de Gestión Pública de la PCM. Lima, 18 de junio de 2009.

<sup>232</sup> Ayuda memoria de reunión entre SGP y SD de la PCM: *Presentación de avances y actualización de la estrategia del proceso de construcción de las matrices, para su consulta a nivel intergubernamental*. Lima, 22 de Julio 2009.

partially, achieving the approval of the matrix from the Ministry of Labor and Employment Promotion by means of Supreme Decree No. 002-2010-TR published on April 10, 2010. Other sectors where there was consultation were: Environment, Energy and Mines, and Transportation and Communications. SGP never submitted the health matrices to ANGR, AMPE and REMURPE<sup>233</sup>

### **5. Matrices of delimitation of competencies and distribution of functions – MINSA and PCM, 2010 - 2011**

SGP took up the coordination with the LOF elaboration commission of MINSA on February 2010, holding thereafter a series of meetings to revise the health matrices. This process was based on the structure of essential processes previously stated by MINSA, and not the one suggested by PCM, and comprised two simultaneous jobs: a) The joint adjustment of national functions incorporating suggestions from PCM, based on their 2009 matrices (with the participation of the LOF commission of MINSA, SGP and SD of PCM); b) the revision of regional and local functions within the commission. Subsequently, PCM suggested adjusting regional and local functions elaborated by the commission, homogenizing them with national functions. Likewise, the commission submitted the matrices to consultation in a limited manner with several MINSA general directorates and offices.

As a consequence of the manner how the above mentioned job was organized, it had a very slow progress, taking more than one year up to March 2011<sup>234</sup>. However, the final product did not only solve the limitations of the matrix of MINSA from 2008 mentioned in the corresponding section, but it even had additional limitations<sup>235</sup>:

- It amended the functions already transferred to governments, significantly restricting the attributions of regional governments in impairment of their autonomy.
- It defined the functions of each governmental level in a very broad manner, being more imprecise in delimitating the competencies of each one for the different processes, and generating greater duplicity in the assignment of functions.

On the other hand, the need for consultation of health matrices with regional governments was dealt with in several meetings of the Intergovernmental Commission on Health (CIGS). Thus, in the I CIGS Extraordinary Session, performed in Ica on March 19-20, 2010, it was agreed to “*Arrange MINSA’s functions matrices in accordance to regional roles and functions in order to avoid duplications and absences*”, by means of an intergovernmental workshop foreseen for April 2010. MINSA did not submit the matrices to the regional governments and the workshop was not carried out. It was not until the V CIGS Ordinary Meeting, held in Lima on March 25-26, 2011, when the subject was retaken and it was agreed that MINSA would submit its proposal to receive contributions and suggestions until April 8, 2011. Regional governments requested a meeting to revise in detail the matrices, which was held on May 31, 2011. However, consensus with the

---

<sup>233</sup> Uribe, Gilda: *Segundo informe de consultoría; Monitoreo y revisión del proceso de validación de las matrices de funciones y los proyectos de ley de organización y funciones de los Sectores del Gobierno Nacional para la delimitación de competencias entre los tres niveles de gobierno*. Lima, mayo de 2010.

<sup>234</sup> Ministerio de Salud: *Matriz de delimitación de competencias y asignación de funciones del sector salud en los tres niveles de gobierno; versión del 26 de mayo de 2011*.

<sup>235</sup> Comunicación del Gobierno Regional de San Martín al MINSA, abril de 2011.

regional governments regarding their corresponding functions was not reached. Finally, a workshop was performed in Junín on June 15, not reaching any agreement as well. Lastly, in the VI GIGS Ordinary Meeting, performed in Junín on June 16-17, 2011, it was agreed that the matrices should incorporate the listing of functions already transferred to regional governments and conclude their revision in a meeting with the representatives of the regions on June 22. This latter meeting was held, reaching consensus regarding regional functions. The matrix incorporated the suggestions of DIRES representatives regarding regional functions and it included an additional column with the already transferred corresponding faculties<sup>236</sup>. It should be noted that only regional functions were submitted to consultation; both AMPE and REMURPE did not accept its discussion in the heart of CIGS, but rather in further meetings organized by the PCM's SGP.

## **6. Distribution of Functions Matrices for Local Governments – MINSA/OD, 2011**

In the context of initiatives oriented to foster local health decentralization, and insofar that MINSA had not defined an agreed proposal of local functions, on May 2010 the MINSA's Decentralization Office (OD) took the initiative to formulate a proposal of functions that would correspond to provincial and district municipalities. For this, it requested the different MINSA general directorates and offices a proposal for each one of the general directorates and offices of MINSA. Subsequently, it systematized the contributions received and made the corresponding consistency with the legal framework, with the technical assistance to the USAID project / Health Policies. The methodology used was based in the corresponding PCM regulations, besides applying additional criteria: Non-duplicity among governmental levels; inclusion of functions only and not of tasks; alignment of local level functions with the other governmental levels; identification of the legal support for each function; distinction among the functions subjected to a transference from those which did not require so, insofar as they were already stipulated in the law of municipalities of 1984. The proposed matrix was completed in August 2010 and comprised six essential processes: Promotion of Primary Health Care Services; Environmental Health; Management and Enforcement of Pharmaceutical Products, Medical Devices and Sanitary Products; Prevention and Control of Epidemics, Emergencies and Disasters; and Health Insurance. Further, since October 2010, it was validated at meetings in Cajamarca, San Martín and Lambayeque, with the participation of regional health directorates and some local governments, being completed in March 2011<sup>237</sup>.

However, such local functions matrices were not considered by the LOF project elaboration commission of MINSA to be incorporated in the delimitation of competencies matrices and assignment of functions of the health sector in the three governmental levels.

## **3.2 Transference of Competencies and Functions**

The Decentralization Bases Law established that the transference of functions will be performed in a progressive manner and through stages<sup>238</sup>, wherein the health sector remained for a fourth and last stage; whereas the amending law of the Organic Law of Regional Governments stated that

<sup>236</sup> Ministerio de Salud: *Matriz de delimitación de competencias y asignación de funciones del sector salud en los tres niveles de gobierno; versión del 6 de julio de 2011.*

<sup>237</sup> Ministerio de Salud / Oficina de Descentralización: *Matriz de distribución de salud a los gobiernos locales; versión de marzo de 2011.*

<sup>238</sup> Congreso de la República: *Ley de bases de la descentralización.* Lima, 2002. Segunda disposición transitoria

health transferences would begin in January 2004<sup>239</sup>. The following table summarizes the regulations referring to the formalization of the functions transference process:

**Table No. 5: Regulations for the Execution of the Functions Transference Process**

Legal Rule	Date of Issue	Main Provisions
Ministerial Resolution No. 1976-2002-SA/DM	December 30, 2002	<ul style="list-style-type: none"> <li>Constitutes the Sectorial Transference Commission of the Ministry of Health, in charge of performing the transference process of competencies and resources to regional and local governments corresponding to the Health Sector.</li> <li>Integrated by: Vice-Minister of Health, two advisors from the Ministerial Office of Health, General Office of Consultancy, General Directorate of Persons-Focused Health and General Office of Planning or its representative.</li> <li>Establishes that the Commission will elaborate the proposal of the Annual Transference Plan for the Health Sector, which will be presented before the National Council for Decentralization, as provided in Article No. 83 of Law No. 27867.</li> </ul>
Ministerial Resolution No. 1292-2003-SA/DM	2003	<ul style="list-style-type: none"> <li>Reset the Sectorial Transference Commission of the Ministry of Health, in charge of performing the transference process of competencies and resources to regional and local governments corresponding to the Health Sector, with some changes among its members.</li> </ul>
Supreme Decree No. 036-2003-PCM	March 30, 2003	<ul style="list-style-type: none"> <li>Approves the transference schedule for 2003 to regional and local governments in terms of funds, social projects and programs of Fight against Poverty, as well as of productive infrastructure of regional scope.</li> </ul>
Ministerial Resolution No. 569-2004-SA/DM	2004	<ul style="list-style-type: none"> <li>Reset the Sectorial Transference Commission of the Ministry of Health, in charge of performing the transference process of competencies and resources to regional and local governments corresponding to the Health Sector. The names of the members who are elected are withdrawn.</li> </ul>
Approves the 2004 – 2006 National Decentralization Plan; CND Directive Council	2004	<ul style="list-style-type: none"> <li>Approves the National Decentralization Plan for 2004 – 2006, aimed to the general objective and the specific objectives with their respective strategies, lines of action and results expected for the decentralization process in such period.</li> <li>Does not include the delimitation of sectorial competences among governmental levels.</li> </ul>
Supreme Decree No. 038-2004-PCM	May 11, 2004	<ul style="list-style-type: none"> <li>Approves the “Annual Transference Plan for funds and social projects, social programs of Fight against Poverty and investment projects of productive infrastructure of regional scope and of sectorial competencies to regional and local governments for the year 2004”.</li> <li>This plan comprised the transference of 62 specific functions in agriculture, foreign trade and tourism, energy and mines, and production.</li> </ul>

<sup>239</sup> Congreso de la República: *Ley N° 27902, ley que modifica la Ley Orgánica de los Gobiernos Regionales N° 27687*. Op. cit. Cuarta disposición transitoria.

Legal Rule	Date of Issue	Main Provisions
Presidential Resolution No. 026-CND-P-2005	March 29, 2005	<ul style="list-style-type: none"> <li>Approves the sectorial transference plan of the five-year period 2005 – 2009.</li> <li>Continued with the sectorial transference in matter of agriculture and of energy and mines, but incorporated for the first time the transference of functions in matters of health and of transportation and communications.</li> <li>The of health transference plan established the transference of 125 faculties between 2005 and 2009.</li> </ul>
Supreme Decree No. 052-2005-PCM	July 2005	<ul style="list-style-type: none"> <li>Approves the annual transference plan of sectorial competencies to regional and local governments of 2005.</li> <li>Did not include the specific requirements of accreditation, despite the fact that it is stipulated in the corresponding regulations.</li> <li>Included 37 faculties corresponding to 13 functions in health of the LOGR; it did not include the identification of the associated economic resources.</li> </ul>
Presidential Resolution No. 065-CND-P-2005	September 22, 2005	<ul style="list-style-type: none"> <li>Approves the specific accreditation requirements, including those corresponding to health functions.</li> <li>Arranged that the stage of training and technical assistance of the accreditation process could be prior or subsequent to the certification.</li> </ul>
Ministerial Resolution No. 189-2006/MINSA	February 24, 2006	<ul style="list-style-type: none"> <li>Approves the MINSA 2006 sectorial transference plan, which included 38 faculties corresponding to 10 functions of the LOGR, with their corresponding specific accreditation requirements from the group of actions.</li> <li>Identified the transference of associated economic resources to these faculties, equivalent to S/. 36'815,629.00.</li> <li>Specified training and technical assistance activities, with 17 theme axis.</li> </ul>
Supreme Decree No. 021-2006-PCM	April 27, 2006	<ul style="list-style-type: none"> <li>Approves the annual transference plan of sectorial competencies to regional and local governments from 2006, which included the 38 faculties of the plan approved by MINSA, with 2 new functions of the LOGR.</li> </ul>
Ministerial Resolution No. 425-2006-SA/DM	May 5, 2006	<ul style="list-style-type: none"> <li>Reset the Sectorial Transference Commission of the Ministry of Health, which incorporates the person responsible of the decentralization office, created in the new ROF of MINSA, approved by Supreme Decree 023-2005-SA. The Commission was formed by the Vice-Minister of Health, General Office of Planning and Budget, General Office of Legal Advice and Decentralization Office.</li> </ul>
Presidential Resolution No. 044-CND-P-2006	May 17, 2006	<ul style="list-style-type: none"> <li>Approves the Middle-term transference plan for 2006 – 2010.</li> </ul>
Ministerial Resolution No. 187-2007/MINSA	February 28, 2007	<ul style="list-style-type: none"> <li>Approves the MINSA 2007sectorial transference plan, which included 88 faculties corresponding to 15 functions of the LOGR, with their corresponding specific accreditation requirements for each function.</li> <li>Identified the transference of associated economic resources to these faculties, equivalent to S/. 57'155,935.00.</li> <li>Included a training program, consisting in academic degrees and internships for each one of the functions of the LOGR.</li> </ul>
Supreme Decree No. 036-2007-PCM	April 12, 2007	<ul style="list-style-type: none"> <li>Approves the annual transference plan for sectorial competencies to regional and local governments for 2007, incorporating the competencies considered in the 2006 Annual Plan as well as those pending since 2004.</li> <li>Speeds up the transference process stating as date of completion December</li> </ul>

Legal Rule	Date of Issue	Main Provisions
		<p>2007.</p> <ul style="list-style-type: none"> <li>Approves the guidelines for the simplified transference procedure, stating that the certification is an assessment process whose procedure must be established by the PCM's Decentralization Secretariat, in coordination with the sectors.</li> </ul>
Ministerial Resolution No. 558-2007-SA/DM	July 11, 2007	<ul style="list-style-type: none"> <li>Reset the sectorial transference commission of the Ministry of Health, in charge of performing the transference process of competencies and resources to regional and local governments corresponding to the Health Sector. Incorporating 2 members, being comprised by the Vice-Minister of Health, General Office of Planning and Budget, General Directorate of Persons-Focused Health, General Directorate for Health Promotion, General Office of Legal Advice and Decentralization Office.</li> </ul>
Supreme Decree No. 001-2008-PCM	January 2008	<ul style="list-style-type: none"> <li>Extends the term to complete the transfereces stipulated by Supreme Decree No. 036-2007-PCM until March 31, 2008.</li> </ul>
Supreme Decree No. 029-2008-PCM	April 16, 2008	<ul style="list-style-type: none"> <li>Postpones again the completion of transfereces stipulated by Supreme Decree No. 036-007-PCM until December 31, 2008.</li> </ul>
Supreme Decree No. 049-2008-PCM	July 17, 2008	<ul style="list-style-type: none"> <li>Approves the annual transference plan of sectorial competences to regional and local governments of 2008.</li> <li>Establishes the guidelines for the identification and quantification of associated resources, of human resources, technical assistance and training, follow-up, monitoring and assessment, structure, and decentralized functioning.</li> <li>Does not include new health functions to be transferred to regional governments.</li> </ul>
Supreme Decree No. 083-2008-PCM	December 24, 2008	<ul style="list-style-type: none"> <li>Sets December 31, 2009 as the maximum date for the transfereces stated in Supreme Decree No. 036-2007-PCM.</li> </ul>
Supreme Decree No. 047-2009-PCM	July 24, 2009	<ul style="list-style-type: none"> <li>Approves the annual transference plan for sectorial competencies to regional and local governments for 2009.</li> <li>Approves other provisions for the development of the decentralization process, development of a decentralized management.</li> <li>Establishes the creation of sectorial Intergovernmental Commissions.</li> <li>Does not include new functions in health to be transferred to regional governments.</li> </ul>
Supreme Decree No. 115-2010-PCM	December 31, 2010	<ul style="list-style-type: none"> <li>Approve the annual transference plan for sectorial competencies to regional and local governments for 2009.</li> <li>Establishes guidelines to consolidate the focus for the development of decentralized management, and the identification and quantification of associated resources.</li> <li>Does not include new health functions to be transferred to the regional governments.</li> </ul>
Ministerial Resolution No. 175-2011/MINSA	March 15, 2011	<ul style="list-style-type: none"> <li>Approves the 2011 Sectorial Transference Plan of the Ministry of Health.</li> <li>Includes a training plan with diplomas as part of the Specialization Program in</li> </ul>

Legal Rule	Date of Issue	Main Provisions
		<p>Health Management and Government (PREG).</p> <ul style="list-style-type: none"> <li>Does not include new health functions to be transferred to regional governments.</li> </ul>

### 3.2.1 Health Transferences in the 2004-2006 Period

#### Functions Transference Process for 23 Regional Governments

As it was already mentioned above, during 2003 the management of Dr. Fernando Carbone and Dr. Álvaro Vidal did not formulate the corresponding health transference plan which made transferences viable. It was not until Dr. Pilar Mazzetti's ministerial management when the formulation of the "*Road Map for Health Sector Decentralization*" started on February 2004, whose proposal was completed in November 2004. Besides containing a distribution of functions matrix proposal for the three governmental levels, such document established the objectives and the strategy for the transference process. Its objectives were as follows.<sup>240</sup>

- To plan the decentralization process, establishing the stages and the sequence of the process; as well as knowing the capacities and potentials to be developed at sub-national levels.
- To guide the process in a gradual and progressive manner, following the criteria established in decentralizing laws.
- To define in a clear and concise manner the distribution of competencies of each process in each stage.

An outstanding aspect of the road map proposal was the differentiation of health functions to be transferred to the regions in three blocks and in a three-stage process.<sup>241</sup>

- *Block 1*, with functions that have already been exerted in a de-concentrated manner with its respective budget by regional governments or functions which did not require much additional regulatory and human capacities; to be delegated or transferred between 2004 and 2005.
- *Block 2*, with functions requiring partially developed capacities at decentralized levels, but which could be corrected with low-cost programs; to be transferred in 2006 or delegated by means of management agreements in 2005.
- *Block 3*, with functions requiring few capacities or non-developed capacities at decentralized levels and which implied important training processes or important regulatory developments, as well as those having increased net fiscal impacts; to be transferred between 2006 and 2009.

Simultaneously to the elaboration of this road map, the ministerial management opened spaces of dialogue with regional governments since April 2004 in order to foster the decentralization process, performing the following meetings:<sup>242, 243</sup>

<sup>240</sup> Guerra-García, G.; Arca, J. M.; Arguedas, C.; Minaya, V.: *Hoja de ruta de la descentralización del sector salud*. Lima, noviembre de 2004.

<sup>241</sup> *Ibídem*.

- I MINSA National Meeting – regional governments (April 2004), wherein it was decided to constitute and maintain this space with a quarterly periodicity. MINSA was requested to speed up the decentralization process and to have ready a schedule for the fourth quarter of that year.
- II MINSA National Meeting – regional governments (July 2004), where it was agreed to sign agreements of delegation of functions and define in an arranged way the transference plan and schedule.
- III MINSA National Meeting – regional governments (October 2004), where the progress of management agreements was analyzed and it was agreed to elaborate a joint proposal of middle-term transference plan between MINSA, regional governments and DIRESA before the end of December 2004.

As it may be noted in the agreement of the II National Meeting, the ministerial management decided to express its institutional will to initiate sector decentralization by means of agreements of delegation, which were aimed to achieve certain autonomy levels by regional public health authorities. The delegated functions were as follows: a) The designation and cessation of officers other than health regional directors as well as of MINSA representatives before the Board of Directors of Charity Societies and Boards of Social Participation; b) manage the enforcement of environmental health activities and arrange for that purpose the resources directly collected; c) the delimitation of networks and micro-networks of their realm<sup>244</sup>. Thus, MINSA signed these agreements with 22 regional governments, approved by means of the proper ministerial resolutions<sup>245, 246</sup>.

On the other hand, in order to implement the agreement of the III National Meeting and after completing its proposal of “*Road Map for Health Sector Decentralization*,” MINSA organized the “I National Workshop on Decentralization”, carried out on December 9-10, 2004, for the revision of the strategy and the schedule of health transfers contained in document<sup>247</sup>. It should be noted that the regional governments also introduced a proposal of regional functions and a schedule of transfers contained in the document called “*Regional Contributions to the Road Map for Health Decentralization*”, agreed upon 22 regional directors of health of the country in a meeting held on November 24-25, 2004. Such regional proposal had been elaborated by analyzing the degree of exercise of such functions and by identifying the limiting factors, being economic, institutional, legal or otherwise. As a result of the meeting, a new version of the transfers schedule was obtained; these agreements gave place to the “*Middle-term Sectorial Health Plan*,

<sup>242</sup> Ibídem.

<sup>243</sup> Ministerio de Salud / Oficina de Descentralización: *Hoja de ruta para la descentralización de la función salud; actualización, avances y agenda pendiente*. Lima, julio de 2006.

<sup>244</sup> For the implementation of this agreement, MINSA issued the R.M. N° 1217-2004/MINSA on December 17th, 2004, authorizing to DIRESAs for revising their Health Networks and Micro Networks delimitation in the region, jointly with their Regional Governments, on the basis of the regulations established in the R.M. N° 122-2001-SA/DM. The changes would approve with Regional Governments resolutions.

<sup>245</sup> Távara, Gerardo y Márquez, Jaime: *Sistematización del proceso de descentralización del sector salud*. 2009. Op. cit.

<sup>246</sup> Ministerio de Salud / Oficina de Descentralización: *Hoja de ruta para la descentralización de la función salud; actualización, avances y agenda pendiente*. Lima, julio de 2006.

<sup>247</sup> Ibídem.

2005-2009” introduced by MINSA to CND. Likewise, several DIRESA took as a base such agreements to submit to the CND their health transference requests, as stipulated by the regulations in force<sup>248</sup>.

Subsequently, in January 2005, MINSA revised such proposals, in order to determine the benefit of the transference of the faculties in the terms stipulated and to specify the conditions or criteria so that the transferees may operate in terms of the existing regulations, practices and processes. The adjusted document was introduced in the “*IV National Meeting between the Ministry of Health and Regional Governments, Building Consensus for the Health Agenda*”, held on February 22-23, 2005, organized by MINSA, with the participation of regional governments of the country. The objective of such workshop was to approve regional competencies and functions, the revised version of the 2005-2009 middle-term transference plan and the accreditation requirements and indicators. The products obtained were collected by MINSA in a new version of the 2005-2009 Middle-Term Health Sectorial Transference Plan and in the 2005 Annual Sectorial Transference Plan, which were introduced to CND at the end of February 2005; being approved as the Sectorial Transference Plan of the 2005-2009 Five-Year Period<sup>249</sup>, although with significant postponements in regards to the transference of most of the competencies. The most outstanding aspect was the reduction of 72 faculties foreseen for 2005 to only 21, wherein MINSA produced the corresponding objection<sup>250, 251</sup>.

After a few months, and after the pressure exerted by the Minister of Health, the Ombudsman and regional governments, the resistance from CND was overcome, at least partially, wherein the transference plan for 2005 was finally approved by the Council of Ministers only in July 2005<sup>252</sup>, several months after the date foreseen in the regulatory framework, which corresponded to April 6 of that year<sup>253</sup>, with 37 faculties for the health sector to be transferred in 2005<sup>254</sup>.

Simultaneously to the approval process of the 2005 plan, regional health directors of the Northern Macro Region organized the “*II Macro-regional Workshop on Decentralization; Towards Successful Accreditation*”, performed on April 21-22 with the purpose of preparing the conditions for the accreditation of regional governments for transferring the functions, including the revision of the proposal of accreditation requirements. Such workshop counted with the participation of representatives of all the regional governments of the country, MINSA, CND and the Ombudsman. Subsequently, MINSA organized the “*V National Meeting between the Ministry of Health and*

<sup>248</sup> Bardález, C.: *Guía Metodológica del Mapa Concertado de Competencias en Salud*. Promoviendo alianzas y estrategias, Abt Associates Inc. Lima, julio de 2006.

<sup>249</sup> Consejo Nacional de Descentralización: *Plan de Transferencia Sectorial del Quinquenio 2005 – 2009*. Resolución Presidencial N° 026-CND-P-2005. Lima, 29 de marzo de 2005.

<sup>250</sup> *Ibíd.*

<sup>251</sup> Ministerio de Salud / Oficina de Descentralización: *Hoja de ruta para la descentralización de la función salud; actualización, avances y agenda pendiente*. Lima, julio de 2006.

<sup>252</sup> Presidencia de la República: *Decreto Supremo N° 080-2004-PCM; Reglamento de la Ley N° 28273 - Ley del Sistema de Acreditación de los Gobiernos Regionales y Locales*. Lima, 16 de noviembre del 2004.

<sup>253</sup> Távara, Gerardo y Márquez, Jaime: *Sistematización del proceso de descentralización del sector salud*. 2009. Op. cit.

<sup>254</sup> Ministerio de Salud / Oficina de Descentralización: *Hoja de ruta para la descentralización de la función salud; actualización, avances y agenda pendiente*. Lima, julio de 2006.

*Regional Governments*”, performed in June 2005, where it introduced to the regions the specific requirements matrix for its enrichment.<sup>255, 256</sup>

After the Annual Plan was approved at the end of July, MINSA organized the “*II National Workshop on Decentralization*” in September 2005, to do the following: Socialize the specific requirements matrix and specific function accreditation indicators and generate agreements to facilitate accreditation; learn the needs on training and technical assistance of regions for the transference process; and introduce the guidelines for re-adapting the organization of regional health directorates.

By the end of 2005, MINSA reached the important achievements for the decentralization process in the health sector and which were also achieved in a discussed and concerted manner with regional governments<sup>257</sup>:

- Identification of health regional functions.
- Definition of a schedule for the transference approved by CND.
- Definition and approval of specific requirements for the accreditation of regional governments<sup>258</sup>.

Subsequently, the “*III National Workshop on Health Decentralization MINSA – Regional Governments*” was carried out on March 2-3, 2006 to define the steps to be followed in order to effectuate the transference and the role of MINSA to support the implementation of the faculties to be transferred. Finally, the “*IV National Meeting with Regional Governments*” was held on July 6 with the purpose of assessing the progress in the fulfillment of the commitments assumed<sup>259</sup>.

As a consequence of executing the 2005 Annual Plan, the certification process of regional governments started between November and December 2005 and the accreditation process between February and June, 2006, headed by CND, wherein 23 regional governments requested the full functions and faculties foreseen in such plan, 17<sup>260</sup> completely accredited to receive the 37 faculties, while three accredited 27 faculties<sup>261</sup>. Tacna did the proper thing with 22 faculties; Moquegua, with 21; and San Martín, with only 17. As a result, the transferences of these faculties and functions were effectuated with the corresponding minutes and reports, although this did not

---

<sup>255</sup> Bardález, C. y Ugarte, Ó.: *Mapa concertado de competencias y proceso de transferencia de funciones en la descentralización del sector salud*. Lima, febrero de 2005. Op. cit.

<sup>256</sup> Ministerio de Salud: *Plan de Transferencia 2006, aprobada con Resolución Ministerial N° 189-2006/MINSA*. Lima, 24 de febrero de 2006.

<sup>257</sup> Consejo Nacional de Descentralización: *Resolución Presidencial N° 065-CND-P-2005*. Lima, 25 de septiembre de 2005.

<sup>258</sup> Ministerio de Salud / Oficina de Descentralización: *Hoja de ruta para la descentralización de la función salud; actualización, avances y agenda pendiente*. Lima, julio de 2006.

<sup>259</sup> Ancash, Amazonas, Arequipa, Apurímac, Cajamarca, Cuzco, Huanuco, Huancavelica, Ica, Lambayeque, Loreto, Junín, Madre de Dios, Pasco, Puno, Tumbes y Ucayali.

<sup>260</sup> Libertad, Piura y Ayacucho.

<sup>261</sup> Resoluciones Ministeriales N° 612-2006/MINSA, 620- 2006/MINSA, 1168- 2006/MINSA y N° 124-2007/MINSA.

include the personnel, documentation, goods or economic resources associated thereto, thereafter the respective ministerial resolutions being issued to 16 regional governments<sup>262</sup> as of July 2007, concluding such process<sup>263</sup>. The first resolutions were signed in the “VI National Meeting with Regional Governments” on July 6, meeting which was also aimed to assess the progress on the fulfillment of the commitments assumed.

On the other hand, on February 2006, MINSA approved through Ministerial Resolution No. 189-2006<sup>264</sup> the 2006 Transference Plan, taking as basis the 2006 – 2010 Middle-term Transference Plan<sup>265</sup>. In fulfillment of the commitment assumed with Regional Governments, the Ministry proposed in this plan the transference of other 38 additional faculties, as it was agreed with regional governments. The document of reference contained: a) A reference to institutional policies which were guiding the decentralization of MINSA; ii) the progress of the first stage of the process, which would conclude with the effective transference of the functions as of March in that year; c) the proposal of 10 functions and 38 faculties to be transferred in 2006; and, d) a proposal of training activities and technical assistance that MINSA had proposed in its 2006 – 2010 Plan.

### **Transference Process of Functions in Lima and Callao**

In the department of Lima, contrary to what happened in the rest of the country where each department gave place to a region, the Lima Region (provinces) was created for the rest of the provinces of Metropolitan Lima and the Metropolitan Municipality of Lima was assigned regional government functions, by virtue of the special regime foreseen for the capital of the Republic. Besides, the Callao Region was created over the basis of the Constitutional Province bearing the same name. Consequently to this decision, the public apparatus had to adapt its territorial jurisdictions.

For the specific case of the department of Lima, there were five health directorates (DISA), which contrary to DIRESA, operated as MINSA decentralized bodies, forming part of the same budgetary set<sup>266</sup>. In order to perform the transference of functions to regional governments in the realm of Lima, it was necessary to restructure the existing DISA and to create the DIRESA of Metropolitan Lima and Lima Provinces. In this context, the reordering was assumed by a Special Commission<sup>267</sup>, which in 2004 started its task performing a study on health administrative adaptation in Lima in function of the regional governments of Lima, in addition to identifying the processes and mechanisms that must be attended to ensure a successful transference<sup>268</sup>.

---

<sup>262</sup> Ministerio de Salud: *Plan de transferencia sectorial del MINSA 2007; Resolución Ministerial N° 187-2007/MINSA*. Lima, 28 de febrero de 2007.

<sup>263</sup> Ministerio de Salud: *Resolución Ministerial N° 189-2006/MINSA*. Lima, 24 de febrero de 2006.

<sup>264</sup> Consejo Nacional de Descentralización: *Resolución Presidencial N° 044-CND-P-2006*. Lima, 17 de mayo de 2006.

<sup>265</sup> Ministerio de Salud / Oficina de Descentralización: *Hoja de ruta para la descentralización de la función salud; actualización, avances y agenda pendiente*. Lima, julio de 2006.

<sup>266</sup> Creada al amparo de la Resolución Ministerial N° 375-2004/MINSA.

<sup>267</sup> Ministerio de Salud / Oficina de Descentralización: *Informe “Reestructuración de los ámbitos de jurisdicción de las Direcciones de Salud en Lima”*. Lima, abril de 2005.

<sup>268</sup> Ministerio de Salud: *Reordenan ámbitos jurisdiccionales de las direcciones de salud de Lima; Resolución Ministerial N° 689-2005/MINSA*. Lima, 14 de septiembre de 2005.

Thus, in September 2005, the reordering of the jurisdictional realms of DISA in Lima<sup>269</sup> was arranged, aimed to match them with regional governments, stipulating the incorporation: a) of the health networks of Cañete-Yauyos, Chilca-Mala and Huarochirí, with their respective decentralized bodies, to the jurisdiction of DISA III in Northern Lima; b) the transference of the health network of Northern Lima VII (which belonged to DISA III Northern Lima) to the jurisdiction of DISA IV Eastern Lima. Additionally, in December 2005, complementary measures were approved for this first stage of reordering of the jurisdictional realms of the different DISA in Lima<sup>270</sup>, so as to ensure the appropriate application of the administrative procedures, enabling an orderly and rational process and without altering the operation of the health centers involved. Finally, in May 2006, the second stage was approved to complete the reordering of jurisdictional realms of the different DISA in Lima<sup>271</sup>, stipulating the incorporation of the hospitals and health networks of the former DISA Northern Lima to the jurisdiction of the DISA V Lima City.

### 3.2.2 Health Transferences in the 2006-2011 Period

However, in spite of the existence of the 2006 annual health transference plan, these were not performed due to the change of government which took place that year in our country. Thus, in November, the new government headed by Dr. Alan García issued the so-called “*decentralization shock*” containing 20 measures, amongst which it was stipulated that the transference to regional governments of all the shared competencies foreseen in the LOGR should conclude before December 31, 2007. This was made official by means of Supreme Decree No. 068-2006<sup>272</sup>, which also stipulated the identification and quantification of budgetary resources associated to functions. In this context, during 2007, the Annual Transference Plan was elaborated for regional governments of that year<sup>273, 274</sup>, which stipulated the transference of all the competencies foreseen in the LOGR to the 25 regional governments, besides those that were not passed on from the 2004, 2005 and 2006 annual plans. Contrary to what happened in the transference of the 2005-2006 period, this plan included the quantification of the resources associated to each competency, as it had been established by Supreme Decree No. 093-2007-PCM<sup>275</sup>. This task was performed by

<sup>269</sup> Ministerio de Salud: *Aprueban directiva administrativa N° 071-MINSA/OGPE-VOI “Medidas complementarias para el reordenamiento de los ámbitos jurisdiccionales de las DISAS de Lima; Resolución Ministerial N° 928-2005/MINSA*. Lima, 3 de diciembre de 2005.

<sup>270</sup> Ministerio de Salud: *Aprueban directiva administrativa N° 084-MINSA/OE-VOI “Medidas para la implementación del reordenamiento de los ámbitos jurisdiccionales de las DISAS de Lima – Segunda etapa”; Resolución Ministerial N° 461-2006/MINSA*. Lima, 16 de mayo de 2006.

<sup>271</sup> Congreso de la República: *Decreto Supremo N° 068-2006-PCM, Establecen disposiciones relativas a la culminación de la transferencia programadas a los gobiernos regionales y locales*. Lima, 13 de octubre de 2006.

<sup>272</sup> Ministerio de Salud: *Aprueba el Plan de transferencia sectorial del MINSA 2007; Resolución Ministerial N° 187-2007/MINSA*, Lima, 28 de febrero de 2007.

<sup>273</sup> Poder Ejecutivo: *Aprueba el Plan anual de transferencia de competencias sectoriales a los gobiernos regionales y locales del año 2007; Decreto Supremo N° 036-2007-PCM*. Lima, 12 de abril de 2007.

<sup>274</sup> Congreso de la República: *Dictan medidas para culminar la identificación y cuantificación de recursos asociados a la transferencia de recursos asociados a la transferencias de funciones sectoriales a los gobiernos regionales, comprendidas en los planes anuales de transferencia 2004 – 200; Resolución Ministerial N° 093-2007-PCM* 7. Lima, noviembre de 2007.

<sup>275</sup> Ministerio de Salud: *Declaran en proceso de transferencia a los órganos que integran la DISA I Callao al Gobierno Regional del Callao; Resolución Ministerial N° 772-2008/MINSA*. Lima, 2008.

a team made up by the MINSA Decentralization, Planning and Administration offices with the different general directorates and offices that were responsible for the functions transferred; thereby identifying the need to transfer S/. 57'155,935.00 Nuevos Soles.

Subsequently, all the regional governments were accredited for the transference of all the functions included in such plan, issuing the respective ministerial resolutions and concluding the process in April 2008. The total budget corresponding to the 2008 fiscal year that was transferred to 23 regional government reached S/. 152'376,949.00, which were executed with direct transferences from the MINSA set to the sets of regional governments for the amount of S/. 33'466,044.00 Nuevos Soles, besides S/. 118'910,905.00 incorporated in the Budget Law of 2008.

However, a significant number of faculties did not have attached their corresponding budgets. Thus, in November 2008 a special MINSA commission was constituted with the purpose of examining the scopes of the budget assigned to MINSA<sup>276</sup>, according to the regulatory framework applicable to the transference of resources to regional governments for the exercise of functions and attributions. Such commission identified an additional amount of S/. 10'264,259.00 Nuevos Soles, which were transferred by means of Supreme Decree No. 084-2009-EF.

### **Transference Process of Functions in Lima and Callao**

In January 2008, after completing the reordering of the jurisdictional realms of the different DISA in Lima, the transference of DISA III and its decentralized bodies to the Regional Government of Lima<sup>277</sup> started, comprising also personal property and real estate, budgetary resources (S/. 138'759,689.00 Nuevos Soles<sup>278</sup>) and human resources, documentation, contractual position and position of obligations as well as the corresponding assets and liabilities. To perform this, work commissions were formed, being integrated by representatives of the Ministry of Health, the corresponding DISA and regional government. Finally, such process was concluded in June 2008<sup>279</sup>.

With regard to Callao, there was no need to do any territorial reordering as the DISA I Callao jurisdiction matched the one from the Regional Government of Callao, so the transference process was developed without any major setback in a period of two months. In consequence, it was started in November 2008<sup>280</sup> and completed in January 2009<sup>281</sup>, comprising besides DISA, the International Health Executive Management and its decentralized bodies. As in the Lima transference, this one also implied personal property and real estate, budget and human

---

<sup>276</sup> Ministerio de Salud: *Declaran en proceso de transferencia a la DISA Lima III y sus órganos desconcentrados al Gobierno Regional de Lima; Resolución Ministerial N° 043-2008/MINSA*. Lima, 24 de enero de 2008.

<sup>277</sup> Ministerio de Salud: *Autorizan transferencia de partidas del Ministerio de Salud al Gobierno Regional del departamento de Lima; Decreto Supremo N° 008-2008-SA*. Lima, 13 de marzo de 2008.

<sup>278</sup> Ministerio de Salud: *Se da por concluido el proceso de transferencia al Gobierno Regional de Lima Resolución Ministerial N° 020-2009/MINSA*. Lima, 23 de junio de 2008.

<sup>279</sup> Ministerio de Salud: *Declaran en proceso de transferencia a los órganos que integran la DISA I Callao al Gobierno Regional del Callao; Resolución Ministerial N° 772-2008/MINSA*. Lima, 1 de noviembre de 2008.

<sup>280</sup> Ministerio de Salud: *Declara que el Gobierno Regional del Callao ha culminado el proceso de transferencia de las funciones sectoriales en materia de salud; Resolución Ministerial N° 003-2009/MINSA*. Lima, 10 de enero de 2009.

<sup>281</sup> Congreso de la República: *Ley de Presupuesto del Sector Público del Año Fiscal 2009; Ley 29289*. Lima, diciembre de 2008. Artículo 7.

resources, documentation, contractual position and position of obligations as well as the corresponding assets and liabilities. The total transferred budget reached S/. 163'896,509.00, which was performed by means of a direct transfer of the set of MINSA to the sets of the regional governments for an amount of S/. 3'588,016.00 Nuevos Soles by means of Supreme Decree No. 035-2009-EF, as well as an amount of S/. 160'308,493.00 by means of the 2009 Public Budget Law.

### 3.3 Progress and Limitations of the Transference Process of Responsibilities

Making a balance of the transference process of responsibilities, we may conclude that there has been the following process:

- In the health sector, this period was centered in the transference of competencies and functions to regional governments, with a strategy of macro-regional and intergovernmental consensus and articulation, which made possible to achieve agreements for an orderly transference of functions and resources.
- Such process implied the transference of the ownership of 16 functions and 124 faculties, corresponding to the total foreseen in the 2005 – 2010 middle-term plan, comprising the faculties agreed upon between MINSA and regional governments.
- This transference has been performed to all regional governments outside the department of Lima, as well as those from Callao and Lima (including their provinces, except for the capital of the Republic).
- Such process was performed in two stages with very different strategies: a) Gradually, during the governmental management of Dr. Alejandro Toledo, between 2005 and 2006, with the purpose of generating the institutional capacities in regional governments that receive functions; b) Intensively, during the governmental management of Dr. Alan García, between 2007 and 2009, aimed to speed up and conclude transferences, independently from the existence of institutional capacities of regional governments for their appropriate exercise.
- Likewise, it comprised the transfer of a total of S/. 465'297,406.00, performed between 2008 and 2009. It should be noted that the 2006 transference of functions did not include personnel or economic resources associated to the functions transferred in that year; whereas in the transference of functions performed between 2008 and 2009, they were indeed partially protected by budgetary funds.
- On the other hand, in 2009, the Ministry of Economy and Finance directly transferred by means of budget law the ordered resources that MINSA was submitting to regional governments, when this modality of budgetary execution was eliminated in the country<sup>282</sup>.

On the other hand, the limitations of the process have been the following:

- Every decentralization process carries on a reordering of competencies and functions amongst the different governmental levels. However, in Peru the transference of responsibilities has been given without the existence of a precise delimitation of competencies and functions

---

<sup>282</sup> Ministerio de Salud / Oficina de Descentralización: *Hoja de ruta para la descentralización de la función salud; actualización, avances y agenda pendiente*. Lima, julio de 2006. Anexo N° 1.

amongst the three governmental levels. After almost ten years since it started, the Peruvian State has not defined the matrices corresponding for their different sectors. This limitation has been partially repaired in the health sector thanks to a consensus process between MINSA and regional governments developed between 2004 and 2005 regarding regional functions and faculties. Nevertheless, there is still a lack of accuracies regarding the functions and faculties that correspond to local governments and to MINSA.

- These problems are actually a consequence of the general design of the Peruvian decentralization process, which restricted it to a mere transference of functions to regional and local governments, together with some training actions, providing a subsidiary character to the other components of the process.
- In this regard, although it is true that there has been some progress in the transference of functions to regional governments, this has not occurred with respect to local governments, despite the fact that it has been one of the central policies established in the 2006 “decentralization shock,” which in theory started the local health decentralization by means of local pilot projects.
- Likewise, the transference of health functions to the Municipality of Metropolitan Lima is still pending.
- However, the ownership transference of functions has only been partially accompanied by the financial resources associated to each one of these, so they may be actually exercised by regional governments. MINSA still keeps some funds assigned to central programs which should have been transferred, besides the fact that after 2009 there has been an increase in some funds for functions that have already been transferred (SERUMS, investments, recruitment of specialists), although under the central administration (see tables No. 6 and 7 and graphic No. 2).
- Likewise, the corresponding sectorial regulatory adaptation has not been performed, despite the fact that it has been precisely identified in the 2006 road map<sup>283</sup>. In this way, there is no appropriate regulatory framework to date for the decentralized exercise of authorization, categorization and accreditation functions of health services, as well as for the regional issue of the public health records of food; therefore, such functions may not be appropriately exercised by regional governments. Thus, national sectorial regulations prior to 2004 show more gaps, do not have a decentralization focus or are inconsistent with the functions transferred. Additionally, an important part addresses regional competency realms or requires revising their scope, application realm and responsibility. Finally, a significant part is supported in the laws already revoked<sup>284</sup>.
- Similarly, there has not been any transference or development of the operational instruments needed for the decentralized exercise of regional functions, thus determining that several

---

<sup>283</sup> Arguedas, Cinthya Arguedas: *Revisión y análisis del marco normativo vigente según las funciones transferidas en el marco del proceso de descentralización*. PARSALUD II. Lima, junio de 2010.

<sup>284</sup> Molina, R.: *Experiencias de Reforma Institucional en gobiernos regionales; Estudio de casos*. Comisión de Descentralización, Regionalización, Gobiernos Locales y Modernización de la Gestión del Estado del Congreso de la República. Lima, octubre de 2010.

transferred functions may not be exercised for this reason. By operational instruments we understand the organizational or technological manners thus required. This happens especially with functions related to sectorial regulation and enforcement, which require national record systems for their actions (issue of public health record of food, etc.), so the transference of such functions has been restricted to an exclusively formal or bureaucratic dimension.

- On the other hand, despite the fact that there was a significant number of functions that had been transferred to the regional governments, this has not had a cause in the elimination thereof in the MINSA documents of organizational management. This problem has been partly due to the late approval of the LOPE, almost 5 years after the date foreseen for starting the decentralization process in 2002. Still, almost four years have gone by since its promulgation and MINSA has not yet submitted a consistent proposal for its new organization and functions. This results in the duplicity of functions with regional governments. The political will to adapt the organization and functioning of MINSA to the decentralization framework should be assessed.

**Table No. 6: Resource Distribution for SERUMS between MINSA and Regional Governments**

(Millions of Nuevos Soles)

	2009	2010	2011
<b>National Government</b>	<b>62,8</b>	<b>64,9</b>	<b>79,1</b>
<b>MINSA</b>	<b>56,5</b>	<b>57,6</b>	<b>69,3</b>
Ministry of Interior	0,3	1,7	4,2
Ministry of Defense	5,9	5,6	5,5
<b>Regional Government</b>	<b>31,3</b>	<b>31,6</b>	<b>33,5</b>
<b>Total</b>	<b>94,0</b>	<b>96,6</b>	<b>112,6</b>

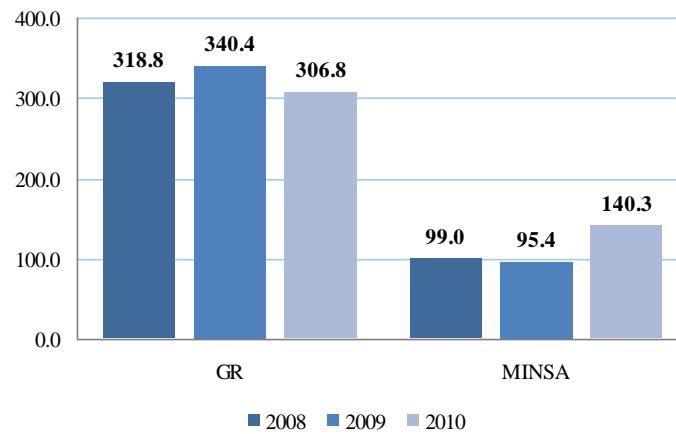
Source: Consulta amigable del SIAF (SIAF Friendly Query). Prepared by: Health Technical Commission of the ANGR  
 (\*) Institutional Opening Budget (PIA). In the previous years, it belonged to execution

**Table No. 7: Resource Distribution for Investment between MINSA and Regional Governments**

(Millions of Nuevos Soles)

	2007	2008	2009	2010	2011
Lima	63,7	2,6	45,7	190,3	305,9
<b>Other regions</b>	<b>8,7</b>	<b>43,1</b>	<b>96,4</b>	<b>76,6</b>	<b>89,4</b>
<b>Total</b>	<b>72,3</b>	<b>45,6</b>	<b>142,1</b>	<b>266,9</b>	<b>395,3</b>

Source: Consulta amigable del SIAF (SIAF Friendly Query). Prepared by: Health Technical Commission of the ANGR  
 (\*) Institutional Opening Budget (PIA). In the previous years, it belonged to execution

**Graphic No. 2: Tendency of SIS Transferences to Public Lenders. 2008 – 2010.**

Source: Head Office Resolutions. Prepared by: ANGR Health Technical Commission

## 4. Institutional Adaptation Processes of the Health Sector in Regional Governments

The institutional adaptation and strengthening is the public policy component of the decentralized process addressed to the reorganization of the different governmental levels, including the adaptation of their management processes and the strengthening of their institutional capacities, intended to the full exercise of their corresponding responsibilities and functions in the framework of the decentralization process.

By representing the decentralization process in a fundamental reform of the State, the *reordering, the organizational adaptation* of any governmental level should constitute one of its essential tasks. It is evident that the transference of their new sectorial competencies and functions to regional governments required them to re-adapt their organizational structure so as to be able to incorporate and exercise such functions, comprising changes both in their regional sectorial directorates and their executive departments, developing capacities to progressively lead and articulate these sectorial functions from a territorial perspective in their regions. In practice, for the regional government it meant incorporating the sectorial directorates, which legally operated as decentralized bodies of the different ministries, to their executive body. In these circumstances, regional governments were facing the challenge of leading a complex middle-term organizational change, accumulating progressive innovations, authorized by their constitutional and exclusive competency of autonomously establishing their own organizational design.

Thus, this component of the decentralization process should comprise the following specific policies:

- The reorganization of governmental levels for exercising the functions transferred.
- The implementation of the necessary arrangements in the administrative instruments to supply governmental levels with the necessary administrative autonomy.
- The strengthening of institutional capacities for exercising the functions transferred.

### 4.1 Organizational Adaptation Processes of the Health Sector in the Institutional Design of the Regional Government

In this sense, one of the crucial processes for successful decentralization is made up by the organizational adaptation of the regional governments to allow them to perform an efficient and effective public management. The decentralization process also introduces other important challenges for their management model: a) Territorial management, which allows to integrate the public policies of economic development and social development, changing the prevailing state sectorial model which entails compartmentalization, duplicity and absences in public policies; b) management by results which surpasses the current model of public management, centered in the control of the budgetary execution, of the established state procedures and in the verification of the attributions of the workers who applied them.

However, in the way that the decentralization process in the country has been designed, centered almost exclusively in the transference of functions and training of personnel, such challenge started from a quite unstable organizational situation of regional governments, which has not been addressed systematically:

- The regional governments were constituted in January 2003 over the basis of the organization of the Transitory Councils of Regional Administration (CTAR), created due to the coup of 1992, whose nature was of a de-concentrated administrative unit of the Ministry of the Presidency and not of a governmental instance. Therefore, the main function of the CTAR was the construction of public works<sup>285</sup>, proper to an administrative unit, and not the formulation, implementation and control of public policies appropriate to their regional reality, proper to a governmental level. Regional governments kept their instances de-concentrated from CTAR, as stipulated by their organic law<sup>286</sup>.
- When regional governments were constituted, the leading bodies were incorporated as established by their organic law: The regional presidency, the legislative body (Regional Council) and the consultative body (Regional Coordination Council), as a superstructure of governance<sup>287</sup>.
- Economic Development, Social Development and Natural Resources Regional Managements along with Environment and Infrastructure Management were added to this basic structure, in parallel with the organic law of regional governments, in order to manage the public policies of their competency. However, this definition was not supported in any organizational design, which enables an efficient and effective organization of management processes, and no actions tending to generate the institutional capacities necessary in these managements were foreseen in order to be developed: The leading of the formulation, implementation, control and assessment of public policies of their competency.
- Regional sectorial directorates were attached to this fragmented structure, initially as instances also dependent upon the corresponding ministries, and after 2006 as instances with full dependency upon the regional government. Regional sectorial directorates had the nature of de-concentrated bodies with functions of programming, execution and control of sectorial policies centrally defined in the ministries, besides organizing and managing the corresponding public services. In this way, they became dependent upon the corresponding regional management, in the case of Health, upon the Social Development Management. Similarly to the above mentioned paragraph, it neither foresees actions aimed at articulating the management processes between both instances.
- The de-concentrated unit of each one of the transferred state sectors was incorporated together with the regional sectorial directorates. In the case of the health sector, they included budget executive units, health networks and CLAS, under the quite confusing and overlapping management models<sup>288</sup>.

The consequence of this spontaneous process of organizational evolution, consisting in a juxtaposition of several organic instances along a relative period of time, is an excessively branched organization with multiples hierarchic levels, vertically fragmented<sup>289</sup> and horizontally

---

<sup>285</sup> Congreso de la República: *Ley Orgánica de los Gobiernos Regionales*. Op. cit. Sexta disposición transitoria.

<sup>286</sup> Molina, R. 2010. Op. cit.

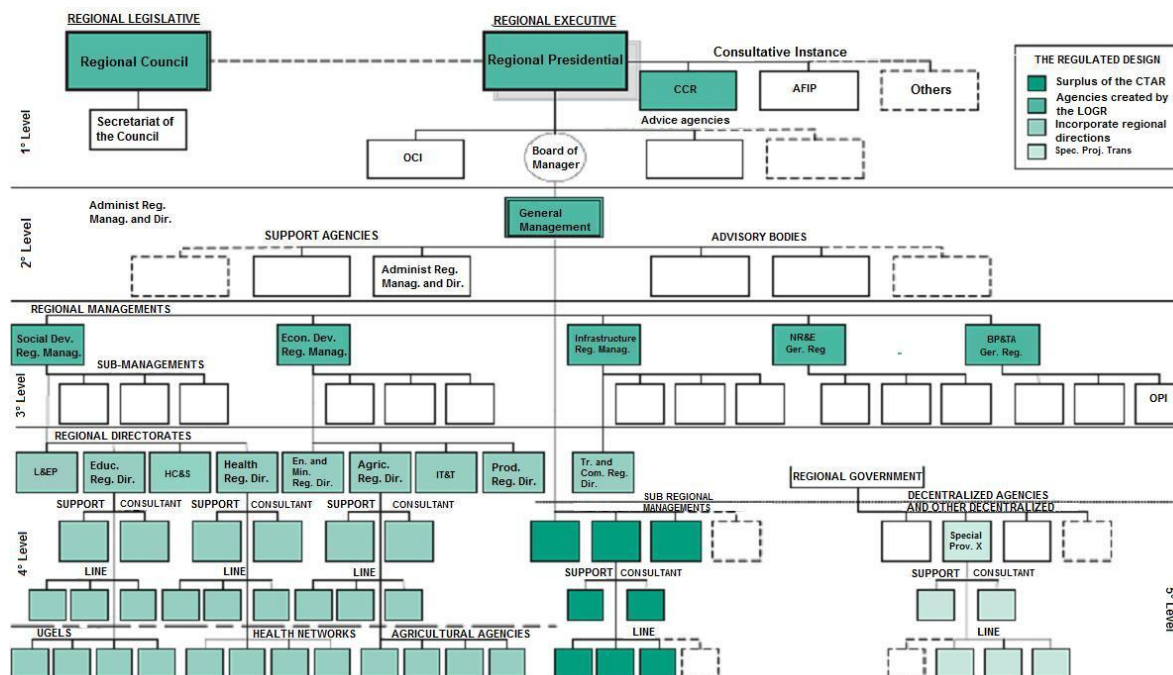
<sup>287</sup> Bardález, Carlos: *Avances en el desarrollo de redes de salud*. Op. cit.

<sup>288</sup> Bardález, Carlos: *Avances en el desarrollo de redes de salud*. Op. cit.

<sup>289</sup> Molina, R. 2010. Op. cit.

compartmentalized. It is evident that its institutional performance is very limited, with marked inefficiency in the fulfillment of its purpose and inefficiency in the profit of resources. The complexity of this organizational design is graphically represented in the flow chart of Graphic No.3:

**Graphic No. 3: Organic structure of the regional governments**



Source: Molina, Raúl. Op. cit.

To this, we must add the limitations in terms of competencies of the inherited human resources, incorporated in many cases with patrimonial criteria along the time of public administrations already existing in the regions. Additionally, the rigidity of the administrative system of centralized design must be considered, as it is focused in controlling expenses. This organizational integration should have been accompanied by:

- The integration of the different labor regimes of the public sector, with multiple sectorial particularities.
- The identification of workers from different regional sectorial directorates with the institutionalism of the regional government, whose sense of belonging corresponded to the relevant ministries.
- The ordering of multiple public administrative units of budget execution existing in the region.
- Significant changes in the planning procedures of public policies aimed at enabling regional governments to perform a middle-term plans establishing their own priorities of public policy and designing and managing such policies.

The above mentioned problems became more evident after 2004 with the progressive transference of sectorial functions to regional governments, which assumed the corresponding responsibility of their exercise after having had the only assignment of administrating the payroll of the personnel of the sectors. In this way, they received both the responsibility of the functions that were already

exercised by the different regional sectorial directorates linked to the provision of public services, as well as of other new ones related to the governmental management of the sectorial governance aimed at guaranteeing the citizen's rights recognized by the State, inherent to the individual or related in their quality of consumers of goods or services. Some of the latter were being exercised by the ministries, but in many other cases no instance was performing them.

In these circumstances and facing the absence of the explicit decentralization policy components which addressed these challenges, since 2007 the own regional governments started processes of institutional reform and modernization, either global in regional executive bodies or approached in some regional health directorates. All of these initiatives sought to solve the management problems derived from the conformation process of its organization and, in theory, they should have had a direct impact in the regional health management<sup>290</sup>. This balance will approach its attention in those reform cases aimed at modifying the organizational location of the health sector within the regional government, as well as reorganization initiatives within regional bodies specialized in health. The global experiences have taken place in the regional governments of Arequipa, La Libertad, Huancavelica, Junín, San Martín<sup>291</sup> and Callao.

#### **4.1.1 Change Processes in the Organizational Location of the Health Sector within the Regional Government**

A central concern of regional governments which started institutional reforms was to articulate the management of their executive body with regional sectorial directorates, aimed at their full incorporation. Solving this problem implies changes in the structural hierarchical dependency as well as in the management processes of sectorial directorates with regard to the several bodies of the regional executive. In general terms, regional governments have developed two different approaches to deal with this concern:

- *Sectorial approach*, oriented to reduce hierarchical levels between the General Regional Management and sectorial directorates, turning them into their direct dependent bodies and eliminating or restricting the competencies of line managements. This approach keeps the sectorial management model of public policies and centralizes the responsibility of the territorial management in the General Management.
- *Territorial approach*, which strengthens line managements (Social Development, Economic Development, Infrastructure and Natural resources and environmental management) in its public policies leading roles in the matters of their competency, strengthening them in their institutional responsibilities and capacities. This approach seeks to change the preexisting sectorial management model for one integrating management in the line regional managements. In the case of health, the responsibility of territorial management lies on the Social Development Management, in terms of leading of the formulation, implementation and control of the integral policies of social development.

The other critical aspect approached in regional government reform initiatives was management reorganization of the operations for provision of public services, forming territorial (provincial) instances which concentrate the services of all sectors, with a single administration of resources in multi-sector executive units. Such initiative has been motivated to achieve better levels of

---

<sup>290</sup> Ibidem.

<sup>291</sup> Ibidem.

efficiency, streamlining and integrating resource management and to control multiple sectorial units currently existing in a same territory<sup>292</sup>. In theory, this model could support the territorial management of public services in local scopes, as well as a better articulation with the local government, resulting in an organizational specialization by territorial realm which would allow adapting the services to the needs and expectations of the population and local authorities.

Table No. 8 shows the summary of organization actions undertaken by regional governments, emphasizing in the matter regarding the precisions about nature and the organizational location of the different DIRESA within the regional government. On the other hand, Table No. 9 systematizes the typology of organizational models in institutional reforms developed by some regional governments. The nature of these three types of experiences developed by the regional government will be given in detail below, analyzing the advantages and disadvantages of each one and describing their current state of development.

**Table No. 8: Nature and Organizational Location of DIRESA in Regional Governments**

Region	ROF	Observations
Amazonas	OR No. 285 - 2011	Abolishes OR No. 274 - 2010 restitutes OR No. 219 - 008. Keeps scheme of multi-sector managements.
Ancash		Keeps scheme of multi-sector managements.
Apurímac	OR No. 027-2005	Keeps scheme of multi-sector managements. Establishes DIRESA Abancay and DISUR Chanka as de-concentrated bodies.
Arequipa	OR No. 010 - 2008 (ROF) OR No. 044 - 2008 (GR Health)	Creation of sectorial managements, elimination of multi-sector managements. Creation of Health Management.
Ayacucho	OR No. 031 - 2005 OR No. 004 - 2007 (Abolishes OR 031 - 2005, approves amendment to the ROF)	Keeps scheme of multi-sector managements. DIRESA as de-concentrated division of the GDS.
Cajamarca	OR No. 020 - 2005 (ROF) OR No. 001-2009 (Amendment)	Keeps scheme of multi-sector managements.
Callao	OR No. 006 - 2008 (ROF) OR No. 003 - 2009 (GR Health) OR No. 001 - 2011 (GR Education) OR No. 013 -2011 (GR Transportation and Communications)	Establishes mixed scheme. Keeps scheme of multi-sector managements and creates the Management of Transportation and Communications, Education Management and Health Management. Keeps DIRESA as de-concentrated body of the Health Management.

<sup>292</sup> Ibídem

Region	ROF	Observations
Cusco	O R No. 002 - 2003 - CRC/RC.	Keeps scheme of multi-sector managements. Social Development Management with sub-management of health as line branch. DIRESA as de-concentrated division.
Huancavelica	OR No. 104 - 2009 (approves ROF GR) OR No. 122 - 2009 (approves ROF GR amendment) OR No. 135 - 2009 (approves ROF GR amendment) OR No. 138 - 2009 (approves ROF GR amendment) OR No. 148 - 2009 (approves ROF GR amendment)	Keeps scheme of multi-sector managements. Forms provincial sub-managements. DIRESA as line organizational branch of the GDS.
Huánuco	OR No. 76 - 2009	Keeps scheme of multi-sector managements. DIRESA as de-concentrated body of the GDS.
Ica	OR No. 0002 - 2006	Keeps scheme of multi-sector managements. DIRESA as de-concentrated body of the GDS.
Junín	OR No. 002 - 2003 OR No. 095 - 2009 (Abolishes OR No. 002 and approves ROF and organic amendment) OR No. 103 -2011 (Abolishes OR No. 095 - 2009, reestablishes OR No. 002 - 2003 and its amendments OR No. 14 - 2008, OR No. 40 - 2008 and OR No. 87 - 2008)	Reverses the organization process with mixed approach. Deactivates Regional Health Management. Reestablishes the scheme of multi-sector managements. DIRESA as line organizational branch of the GDS.
La Libertad	OR No. 023 - 2008 (ROF GR) OR No. 20 - 2010 (Amendment) OR No. 004 - 2011 (ROF GERESA)	Creation of sectorial management, elimination of multi-sector managements. Creation of Health Management
Lambayeque	OR No. 009 - 2011	Creation of sectorial management, elimination of multi-sector managements. Creation of Health Management.
Lima Provincial	RER No. 511-2005-PRES	Keeps scheme of multi-sector managements. DIRESA as de-concentrated body of the GDS.
Loreto (*)	OR No. 013-2005-GRL/P Regional R.E. No. 2049-2009-	Keeps scheme of multi-sector managements. DIRESA as de-concentrated body of the GDS.

Region	ROF	Observations
	GRL-P	
Madre de Dios	OR No. 015 - 2008 (ROF) OR No. 023 -2008 (Amendment)	Keeps scheme of multi-sector managements. DIRESA as de-concentrated body of the GDS.
Moquegua	OR No. 002 -2003	Keeps scheme of multi-sector managements. DIRESA as <b>de-concentrated line</b> branch of the GDS.
Pasco	OR No. 157 - 2008	Keeps scheme of multi-sector managements. DIRESA as line organizational branch of the GDS.
Piura	OR No. 111- 2006 (ROF) OR No. 194 - 2010 (Amendment)	Keeps scheme of multi-sector managements. DIRESA as de-concentrated body of the GDS.
Puno	OR No. 005 - 2008	Keeps scheme of multi-sector managements. DIRESA as de-concentrated body of the GDS.
San Martín	OR No. 037 - 2010	Keeps scheme of multi-sector managements. DIRESA as de-concentrated body of the GDS.
Tacna	OR No. 002 -2003 OR No. 004 - 2006 (Amendment)	Keeps scheme of multi-sector managements. DIRESA as de-concentrated body of the GDS.
Tumbes	OR No. 20 - 2008	Keeps scheme of multi-sector managements. DIRESA as de-concentrated body of the GDS.
Ucayali (*)	OR No. 018-2005-GRU/CR	Keeps scheme of multi-sector managements. DIRESA as de-concentrated body of the GDS.

Source: Prepared based on organizational management documentation from the corresponding regional governments.

(\*) León, A.: Balance of the health reorganization process in regional governments<sup>293</sup>.

<sup>293</sup> León, Ana M.; *Balance del proceso de reorganización de salud en los gobiernos regionales*. En: Taller de intercambio de experiencias sobre reorganización de las DIRESA en los gobiernos regionales. Ministerio de Salud / Oficina General de Planificación y Presupuesto. Tarapoto, 11 de junio de 2010.

**Table No. 9: Typology of Organizational Models in Institutional Reforms of Regional Governments**

Typology	Characteristics	Current Situation
<b>Conversion of regional directorates in managements</b>  (Arequipa, La Libertad, Callao, Lambayeque and Junín)	Adopts a structured organization model based on specialized sectorial managements as line organizational branches dependent upon the General Regional Management, whereby the institutional operational capacity in each one of the fields of regional action is displayed.	In all the cases, Health Managements (former Regional Health Directorates) have kept their structure of de-concentrated body, the control of their executive unit and the control of their de-concentrated divisions, which do not constitute line organizational branches in practice. The Junín region has started since January 2011 a new reorganization process, deactivating this model.
<b>Strengthening of Regional Managements</b>  (San Martín)	Adopts a structured organization model based on multi-sector management, incorporating regional sectorial directorates as line organizational branches dependent upon their respective regional managements, with a leading role of the formulation and implementation of health policies in the region, de-concentrating direct management of public services in their sectorial operational units.	The San Martín Regional Health Directorate is considered in the ROF of the Regional Government as a line organizational branch dependent upon the Social Development Management, keeping its structure of de-concentrated body and the control of its de-concentrated divisions (health networks). Has transferred the executive unit to the San Martín health network, without being administratively incorporated to the UE of the Regional Government.
(Apurímac)	Adopts a structured organization model based on multi-sector management, keeping regional directorates as de-concentrated organizational branches with technical dependency upon their respective regional managements, but without any internal change in their roles and general functions.	The Apurímac region has approved its structural flow chart establishing the Abancay Regional Health Directorate and the Andahuaylas Health Sub-regional Directorate, both dependent upon the Social Development Management.
<b>Creation of De-concentrated Multi-sector Executive Units</b>  (Huancavelica)	Adopts an organizational design based on sub-regional managements in the local-provincial realms, with a multi-sector and de-concentrated character, incorporating the different operational units of provision of services from different sectors as their line organizational branches. These regional managements have dependency on the General Regional Management.	The Huancavelica region has started the implementation of its territorial units. Sectorial directorates have kept their organic structure, although they do not have any more the control over their de-concentrated divisions. Requires a clear identification of roles and functions in all sectors (provision of goods and services).

Source: Prepared based on organizational management documentation from the corresponding regional governments.

### **Conversion of Regional Sectorial Directorates in Regional Sectorial Managements**

In May 2007, the Regional Government of Arequipa was the first one to perform an institutional reform<sup>294</sup>, orientated to the incorporation of regional sectorial directorates and to break the political trend exercised by the ministries over these instances, turning them into nine regional managements and eliminating the Economic Development, Social Development and Environment and Natural Resources Managements established in its Organic Law. In consideration of such a radical measure, there was the assumed bureaucratic and inefficient character of these three regional managements established in the law<sup>295</sup>. This amendment had the following advantages:

- Eliminates an organizational level in a complex and overgrown structure such as the one for regional governments.
- Brings sectorial directorates closer to the high decisive political and administrative instances of the regional executive.

This model was further applied by La Libertad<sup>296</sup> in 2008 and by Lambayeque<sup>297</sup> in 2011, with a quite similar organizational design. On the other hand, regional governments of Callao in 2008<sup>298</sup> and Junín<sup>299</sup> applied a partially similar organizational design, turning regional health directorates into regional managements dependent upon the General Management, but keeping some Social Development regional managements with fewer competencies. The new Regional Government of Junín abolished the amendments introduced<sup>300</sup> in January 2001.

Actually, the model does not guarantee by itself a greater degree of incorporation of sectorial directorates into the Regional Government, which is more dependent upon the degree of direct access of the officials responsible before the regional president and general manager. The background problem was the situation created in these three managements resulting from the transference of sectorial directorates, which required several types of arrangements, stated in the above section, for its orderly incorporation by means of the articulation of the corresponding management processes and the strengthening of their capacities; none of these arrangements was developed in any regional government. The simplest way was chosen to eliminate these

<sup>294</sup> Gobierno Regional de Arequipa / Consejo Regional: *Aprueban modificación de la estructura orgánica y del reglamento de organización y funciones del Gobierno Regional Arequipa; Ordenanza Regional N° 010-Arequipa*. Arequipa, 14 de mayo de 2007.

<sup>295</sup> Molina, R. 2010. Op. cit.

<sup>296</sup> Gobierno Regional de La Libertad / Consejo Regional: *Aprueba la modificación de la estructura orgánica del Gobierno Regional La Libertad y consiguiente organigrama estructural, así como su reglamento de organización y funciones; Ordenanza Regional N° 023-2008-GRLL/CR*. Trujillo, 14 de julio de 2008.

<sup>297</sup> Gobierno Regional de Lambayeque/ Consejo Regional: *Aprueban la actualización del reglamento de organización y funciones del Gobierno Regional de Lambayeque; Ordenanza Regional N° 009-2011GR.LAMB./CR*. Chiclayo, 20 de abril de 2011.

<sup>298</sup> Gobierno Regional del Callao / Consejo Regional: *Ordenanza Regional que aprueba el reglamento de organización y funciones del Gobierno Regional del Callao; Ordenanza Regional N° 006*. Callao, 11 de marzo de 2008.

<sup>299</sup> Molina, R. 2010. Op. cit.

<sup>300</sup> Gobierno Regional de Junín / Consejo Regional: *Ordenanza Regional que deroga la Ordenanza Regional N° 095-2009-GRJ/CR y la Ordenanza Regional N° 099-2009-GRJ/CR; Ordenanza Regional N° 103-2011-GRJ/CR*. Huancayo, 11 de enero de 2011.

managements, with the cost of reinforcing a sectorial management model instead of strengthening its leading roles of integral policies in the region.

Here we must add that this conversion also implied the transformation of regional sectorial directorates into line organizational branches dependent upon the General Regional Management, as established by their corresponding ROF. It must be mentioned that these ROF did not include the organic structure of these new line organizational branches, but that it was rather specified in their corresponding ROF, as if they were keeping their nature of de-concentrated bodies. This change requires the restructuration of these sectorial directorates and the migration from de-concentrated bodies to line organizational branches lacking their support and consultancy organizational branches. However, this has not happened in any of the three experiences developed, and internally in their regional health management few changes may be noted with regard to the previous organizational scheme, not distinguishing from most of the DIRESA, except for their direct dependency upon the General Management, keeping all their support and consultancy organizational branches. Additionally, they continue administrating the budget executive units of health networks located in the capital of the department. The other health operational instances (health networks and micro-networks) have kept their organizational scheme and administrative autonomy, with their direct dependency upon the set of the regional government.

### ***Strengthening of Multi-sector Regional Managements***

In December 2010, the Regional Government of San Martín started the reorganization process of its executive body<sup>301</sup>, adopting an organizational design based on multi-sector regional managements, incorporating regional sectorial directorates as line organizational branches dependent upon their respective regional managements. Additionally, it specifies the roles of these sectorial directorates as instances of strategic leading for the formulation and implementation of health policies in the region, simultaneously de-concentrating the direct management of public services in their sectorial operational units. This model has the following advantages:

- Asserts regional authority in front of the remaining sectorial power in regional sectorial directorates.
- Fosters inter-sector coordination, helping the management of integral public policies.

This model necessarily requires the strengthening of the institutional capacities of these regional managements, in terms of competencies for an integrated leading of the formulation, implementation, control and evolution of public policies in their competency realms. Additionally, there is a need to restructure regional sectorial directorates for their migration from de-concentrated instances with their own advice and support organizational branches into instances which only count with line organic units for the performance of the essential sectorial processes.

Currently, the implementation of this new organizational design in San Martín is incipient and limited to the executive body, wherein the regional management lacks strength. On the other hand, sectorial directorates still keep the structure of de-concentrated bodies, except for DIRESA. The latter has completely de-concentrated the management of services provided to health networks, ceasing to be the budget executive unit, although it has not still been administratively incorporated

---

<sup>301</sup> Gobierno Regional San Martín / Consejo Regional: *Aprueba el reglamento de organización y funciones del Gobierno Regional San Martín; Ordenanza Regional N° 037-2010-GRSM/CR*. Moyobamba, 14 de diciembre de 2010.

to the Budget Executive Unit of the Regional Government, giving more opportunities to develop its role of regional governance.

A less sophisticated and more precise variant was also developed in the Regional Government of Apurímac<sup>302</sup>, with a structured organizational model based on multi-sector managements with a role of strategic leading, although keeping regional sectorial directorates as de-concentrated bodies with technical dependency of their respective regional managements, but without an internal change in their role and general functions.

### **Creation of De-concentrated Multi-sector Executive Units**

In December 2009, the Regional Government of Huancavelica started a reform process in local de-concentrated bodies<sup>303</sup>, with an organizational design based in sub-regional managements in provincial local realms, of multi-sector and de-concentrated character, incorporating as line organizational branches the different operational units of provision of services for the different sectors. These regional managements have dependency of the General Regional Management and are provided with multi-sector budget executive units. The aims of this reform were the following: a) Facilitate the access and inclusion of the population who is farthest from Regional Government services, so that each province may attend its demands in a more efficient manner; b) de-concentrate the administrative and financial management of the Regional Government. These changes implied a de-concentration process on the administration of human, financial and logistic resources comprised in the provision of public services in a single budget executive unit, keeping the specialized technical regulatory character of regional sectorial directorates and exempting it from administrating such resources<sup>304</sup>.

It is evident that one of the main advantages of this organizational design is that it significantly simplifies and rationalizes the structure of regional government executive units by placing them under the dependency of a single management, which allows unifying administrative posts. The other advantage is that it could support the territorial management of public services in local realms, as well as a better articulation of local governments, resulting in an organizational specialization per territorial realm, which will facilitate the adaptation of services to the needs and expectations of the population and local authorities.

However, it seems like the main motivation has been to improve the efficiency of the administration of health services resources and to achieve a better control in the use of these resources, and that due to its implementation, it did not foresee some of the limitations presented:

---

<sup>302</sup> Gobierno Regional de Apurímac / Consejo Regional: *Aprueba el reglamento de organización y funciones del Gobierno Regional de Apurímac; Ordenanza Regional N° OR N° 027-2005- GRA/CR*. Abancay, 2005.

<sup>303</sup> Gobierno Regional de Huancavelica / Consejo Regional: *Ordenanza que aprueba la modificación del reglamento de organización y funciones (ROF), estructura orgánica y cuadro para asignación de personal (CAP) del Gobierno Regional de Huancavelica y modificación del cuadro para asignación de personal (CAP) de las gerencias subregionales de Tayacaja y Huaytará; Ordenanza Regional N° 148-GOB.REG-HVCA./CR*. Huancavelica, 29 de diciembre de 2009.

<sup>304</sup> Pereyra, Juan: *Presentación de la experiencia del Gobierno Regional de Huancavelica en su reorganización institucional*. En: Taller de intercambio de experiencias sobre reorganización de las DIRESA en los gobiernos regionales. Gobierno Regional de Huancavelica. Tarapoto, 11 de junio de 2010.

- It did not specify the internal organic structure of line sectorial units from sub-regional managements, stipulating that the same structures of their operational units should be maintained along with their support and advisory bodies, adding another instance in practice (sub-regional management) above all of them.
- The link and the dependency level that these managements had with regional sectorial directorates was not clearly established, thus weakening the governance capacity of regional sectorial directorates.
- The processes and functions for the delivery of public services to the population were not clearly established.

Actually, this model of institutional reform implies a quite complex implementation process, requiring: a) Restructuring the inside of operational sectorial instances; b) profiles of competencies elevated for a territorial administrative and technical management in this type of sub-regional managements; c) a careful management of the resistances generated in the workers of the different sectors when losing their sectorial identity.

#### 4.1.2 Processes of Organizational Adaptation within Health Directorates

##### 4.1.2.1 Organizational Adaptation of the Administrative Headquarters of DIRESA

In regards to the organizational development of regional health directorates, performed during the decentralization process for the adaptation thereto, most of the regional governments have centered their efforts in the application of the standardized model established by MINSA in May 2003<sup>305</sup>, as shown in Table No. 11. It should be noted that this regulation was in opposition to the decentralization process, as it was already mentioned in the section on the initial situation in the regions, by establishing a unique and rigid model for all the country that was not in accordance with the organizational autonomy instituted as a constitutional and exclusive competency in the legal decentralization framework. Furthermore, this regulation assigned to DIRESA a restricted service provision role and a structure that was not in accordance with its new nature of public health authority (see graphic below). By systematizing the information of such table, the following situations of organizational development of DIRESA may be basically stated:

- Most of the DIRESA (10) keep to date the standardized organizational design established by the stated By-law issued by MINSA in 2003 (Graph No. 5)<sup>306</sup>, which we will call organizational model A (Cajamarca, Callao, Ica, Junín, Lambayeque, Lima Province, Madre de Dios, Piura, Tumbes and Ucayali).
- A second group of five DIRESA (Ancash, Ayacucho, Cusco, Loreto and Puno) has rather adopted an organic structure according to one of the organizational models proposed in the corresponding MINSA By-law issued in 2005<sup>307</sup> (organizational model B).

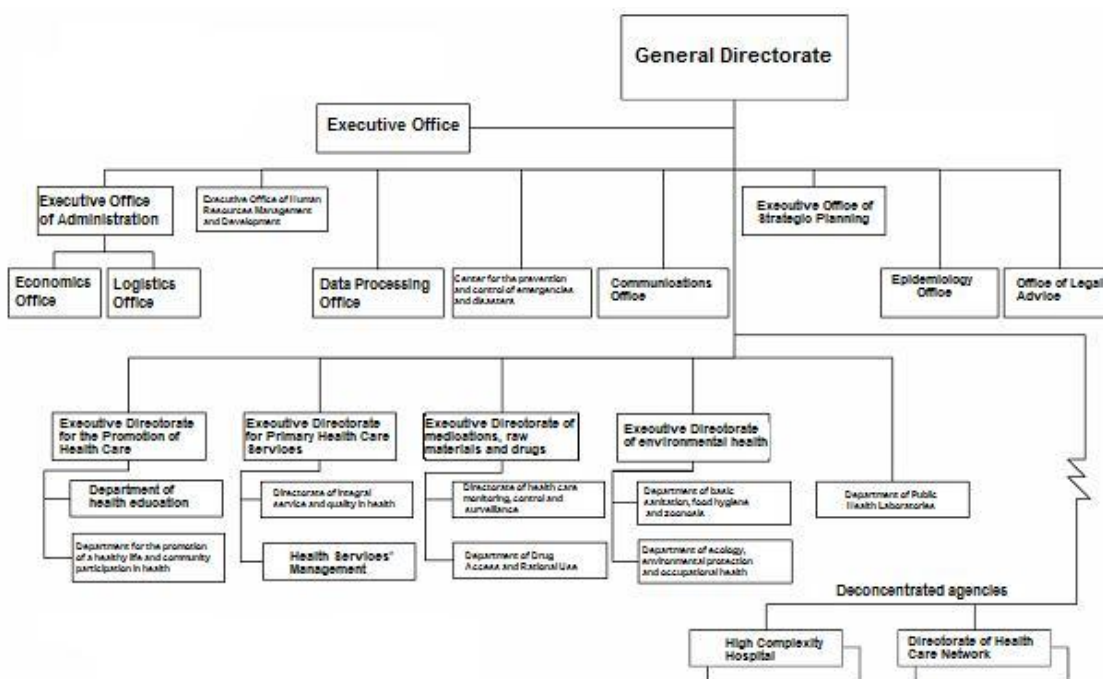
<sup>305</sup> Ministerio de Salud: *Aprueban reglamentos de organización y funciones de las direcciones de salud y de las direcciones de red de salud; Resolución Ministerial N° 573-2003-SA/DM*. Lima, 23 de mayo de 2003.

<sup>306</sup> *Ibíd.*

<sup>307</sup> Ministerio de Salud: *Aprueba los Lineamientos para la adecuación de la organización de las Direcciones Regionales de Salud en el marco del proceso de descentralización; Resolución Ministerial N° 566-2005-MINSA*. Lima, 22 de julio 2005

- A third group of eight regions has developed its organizational scheme incorporating adaptations aiming to be similar to the organic structure that MINSA has been developing. Five of them (Apurímac, Arequipa, Huánuco, Moquegua and Pasco) have done this over the standardized structure established by MINSA by means of RM No. 573-2003-SA/DM (organizational model C - 2003), while three DIRESA (Amazonas, Huancavelica and Tacna) have done this over the base of the organizational designs suggested by MINSA through RM No. 566-2005/MINSA (organizational model C - 2005).
- On the other hand, a very reduced number of two regional health directorates (La Libertad and San Martín) have sought to adapt their structure for fulfilling the functions transferred, based on an own organizational design.

**Graphic No. 5: Organic Structure of DIRESA Established in Ministerial Resolution No. 573-2003-SA/DM, 2005.**

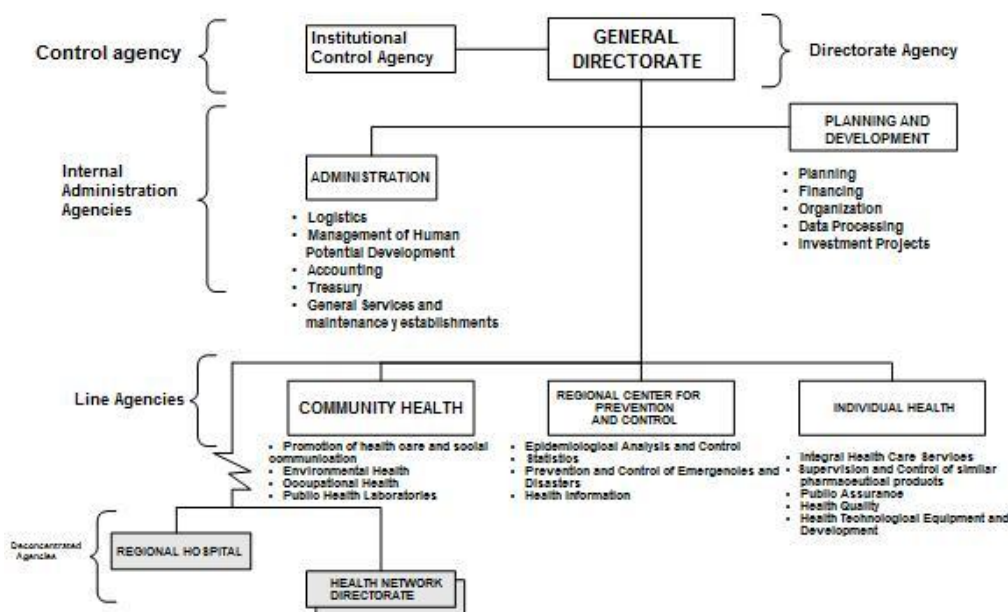


A general balance of the organizational adaptation process of DIRESA enables to conclude that most of them keep an organizational scheme of the stage prior to the decentralization process and which was established by MINSA in 2003 for its standardized application and without variants in the several regions of the country. This organizational design considered DIRESA as administrative de-concentrated bodies of MINSA, without the corresponding political and administrative autonomies instituted with decentralization, besides not regarding them as members of a governmental level with the corresponding functions. Therefore, this design favored the functions for health services provision and reflected the design of MINSA, whereby each ministerial general directorates and offices had its corresponding counterpart in the regions, thus contributing the compartmentalization existing in MINSA. This design neither allows a clear separation of the functions of management, leading, organization and control of health services by the DIRESA headquarters for the functions for providing such services by hospitals and health networks.

Likewise, in most of the cases the DIRESA have kept the role of administrators of some health networks in their region.

With regard to the organizational designs proposed in the MINSA By-law of 2005, it should be noted that they actually correspond to a basic model with a unique criteria of organizational specialization for DIRESA line organizational branches: the specialization per type of operations of each one: Community Health, Individual Health and Emergencies and Disasters. The difference of this basic model is: a) Model 1, constituted by the basic core of the model (with functions of consultancy and support in management and data processing for Emergency and Disasters); b) Model 2, to which some functions of consultancy and support to Emergencies and disasters (planning and organization) have been added); c) Model 3, which adds to the basic model a line organizational branch for health system administration and another one for health system planning and development. Actually by calling a line organizational branch a body that corresponds to a support or advisory body does not change its intrinsic nature, resulting in practice that the three models are reduced to a single one (see Graphic No. 6). The advantage of this model is that it introduces a specialization criterion different from the one used in MINSA and the standardized model of 2003, allowing integrating the functions of line organizational branches according to their own operations: Community Health (integrating health promotion with environmental health), Individual Health and Emergencies and Disasters. A limitation could be that there is little emphasis to develop functions of sectorial regulation and enforcement, proper of a public health authority; besides the little delimitation of competencies among executive departments of Emergencies and Disasters and Collective Health, which would involve functions duplicity.

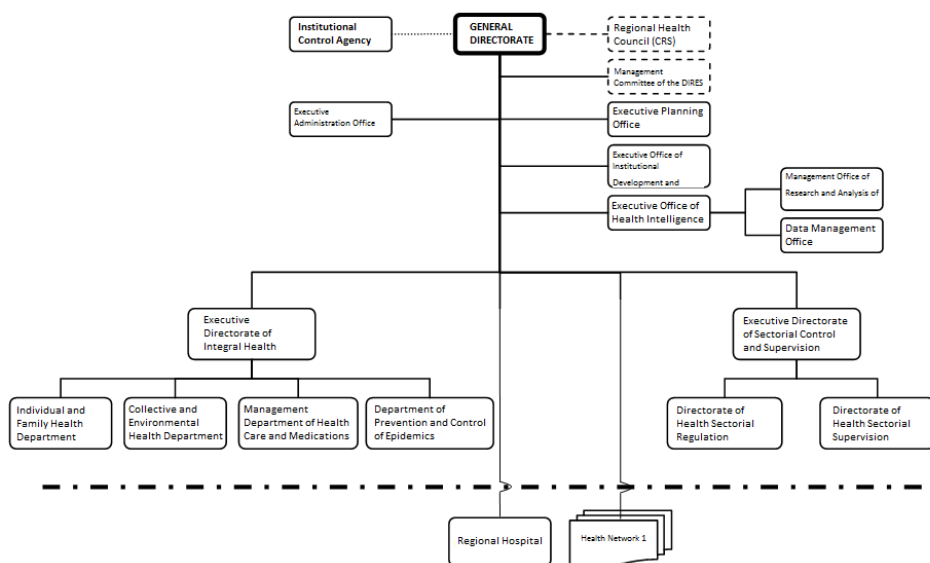
**Graphic No. 6: Basic Organizational Design of DIRESA suggested in Ministerial Resolution No. 566-2005-MINSA, 2003.**



With regard to the fourth group of DIRESA, it should be mentioned that in the cases of San Martín and La Libertad, they constitute quite incipient experiences in regards to their implementation:

- In September 2009 the Regional Government of San Martín approved the reorganization of its DIRESA<sup>308</sup>. The organizational design specialize the line organizational branches per type of DIRESA basic function: Integral Health and Health Sectorial Regulation and Enforcement. That is, the provision of public services and the regulation and enforcement of the public and private health sector. Likewise, it creates an Office of Institutional Development and Quality, besides incorporating two advisory bodies: the Management Commission and the Regional Health Council. However, despite being in the reorganization process for two years, the degree of occupation of the foreseen positions is 55% only (see Table No. 10), wherein there are departments and offices with a quite lower degree (Executive Department of Health Sectorial Regulation and Enforcement, corresponding to a new organic unit). It should be mentioned that this reform seeks to specialize the administrative headquarters of DIRESA into a health technical body, focused on leading, managing and controlling the sector in the region, de-concentrating the administrative tasks of the health public services management in hospitals and health networks, detaching from the corresponding budget executive unit and incorporating the budget for its operation in the executive unit of the Regional Government.

**Graphic N° 7: Organizational Design of DIRESA San Martín, 2009.**



<sup>308</sup> Gobierno Regional de San Martín / Consejo Regional: *Aprueba reglamento de organización y funciones de la Dirección Regional de Salud de San Martín. Ordenanza Regional N° 027-2009-GRSM/PGR*. Moyobamba, 14 de septiembre de 2009,

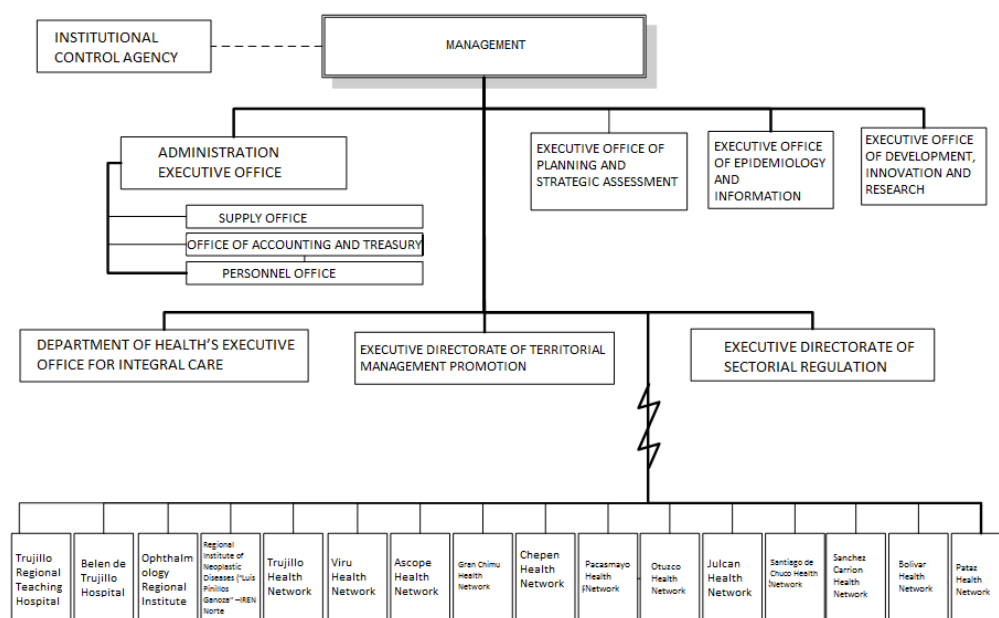
**Table N° 10: Degree of Position Occupation in DIRESA San Martín**

<b>DIRESA Departments</b>	<b>Positions Occupied</b>	<b>Total Positions</b>	<b>%</b>
General Directorate	8	9	89%
Institutional Control Office	4	6	67%
Executive Office of Strategic Planning	6	9	67%
Executive Office of Institutional Development and Quality	5	8	63%
Executive Office of Public Health Intelligence	9	15	60%
Administration Executive Office	6	11	55%
Individual and Family Health Department	17	28	61%
Executive Department of Health Regulation and Enforcement	3	20	15%
<b>Total</b>	<b>58</b>	<b>106</b>	<b>55%</b>

Source: Regional Health Directorate of San Martín, August 2011.

- Recently, in May 2011, the Regional Government of La Libertad approved the reorganization of its Regional Health Management<sup>309</sup>, which will be implemented in the short future. The organizational design specializes line organizational branches per type of operations that each one performs: Integral Health Care, Promotion of Territorial Management and Sectorial Management. That is, the provision of public services for individual care, collective health interventions and regulation and enforcement of the public and private health sector. Likewise, it creates a Development, Innovation and Research Office. Just like in San Martín, it seeks to specialize its administrative headquarters in leading, managing and controlling the sector in the region, de-concentrating great part of the administrative tasks on the management in health care public services in hospitals and health networks. It is still attached to the budget executive unit of the Health Network of Trujillo.

<sup>309</sup> Molina, R. 2010. Op. cit.

**Graphic No. 8: Organizational Design of GERESA in La Libertad, 2011.**

It must be noted that in the cases of San Martín and La Libertad, a line organizational branch responsible for all the actions of regulation and enforcement of the public and private sector in their regions has been incorporated, including therein all the matters of management: Health services, environmental health and pharmaceutical facilities and products, in order to generate a higher specialization in its exercise and sharing common resources, systems and procedures. These amendments are clearly oriented to be adapted to the decentralization process, incorporating its role of public health authority. Additionally, it accurately separates the function of organization and provision of public services from the one corresponding to the regulation and enforcement of such services that in the rest of DIRESA are unified in the same instances, turning the latter ones in both judge and jury in verifying the fulfillment of the sectorial regulations in force.

Likewise, in both cases, it separates the responsibilities for sectorial leading, management and control of the operational units for the provision of services, with more clarity in San Martín, where even DIRESA has transferred the executive unit of the San Martín Network, detaching every administrative task from the resources involved in the provision of services. In the rest of the regions, DIRESA o GERESA exercise management functions in health networks of at least the corresponding capital city of the department, distracting in these tasks what should be their main role as authority of regional public health and of planning, management and monitoring of the regional health policy<sup>310</sup>.

<sup>310</sup> Molina, R. 2010. Op. cit.

**Table Nº 11: Comparative Table of Organization Schemes for Regional Health Directorates or Managements**

Region	ROF	Observations	Roles	Dependency	General Functions
Amazonas	Approved with O.R. No. 270-2010 (10-09-2010).	ROF formulated in the framework of D.S. No. 043-2006-PCM and R.M. No. 566-2005/MINSA  Groups together in the Executive Department of Persons-Focused Health all the collective interventions and keeps the Executive Department of Medications and Raw Materials and Executive Department of Public Health Intelligence as line organizational branches. It keeps the Regional Laboratory as line organizational branch. Type C (2005).	Not defined	De-concentrated Body of the Amazonas Regional Government directly dependent upon the line organizational branch of the Social Development Management.	Replicates RM. No. 566-2005/MINSA.
Ancash	Regional Ordinance No. 017-2008 dated 10/12/2008	ROF formulated in the framework of D.S. No. 043-2006-PCM. Organization in accordance to R.M. 566-2005/MINSA, applies almost literally scheme 1 of such resolution. Type B.	Not defined	Line organizational branch dependent upon the GDS.	Replicates RM No. 573 - 2003
Apurímac	R.E.R. No. 175-2004 del 24/09/2004	ROF formulated in the framework of D.S. No. 043-2006-PCM and R.M. No. 566-2005/MINSA. Its organization reflects the changes that were established in the organic structure of MINSA. Incorporates Infrastructure and Equipment, Human Resources and Public Health Intelligence as line organizational branches, forming seven (7) line organizational branches and amending the model approved in R.M. No. 573-2003-SA/DM. Type C (2003).	No information available	De-concentrated body of the Social Development Management.	No information available
Arequipa	Regional Ordinance No. 044-2008 del 14/03/2008	ROF formulated in the framework of D.S. No. 043-2006-PCM. The organic structure does not have an Inst. Control Body; the Office of Epidemiology is defined as a line organizational branch and not as an advisory body. The Department of Insurances, References and Counter references is created as a line organizational branch. The Office of Communications and the Center for Prevention and Control of Emergencies and Disasters have been deleted.  Amends the model approved in R.M. 573-2003-SA/DM. Type C (2003).	Not defined	Line organizational branch which functionally and administratively depends upon the Regional General Management of the Regional Government.	Amends RM No. 573 - 2003
Ayacucho	Regional Ordinance No. 016-2010	ROF formulated in the framework of D.S. No. 043-2006-PCM and R.M. No. 566-2005/MINSA, applies almost literally scheme 1 of such resolution. Support bodies are reduced and new line organizational branches are considered. Likewise, functions are integrated in the Individual and Community Health Departments. Type B.	Not defined	Line organizational branch of the Regional Management of Social Development from the Regional Government, which by delegation of the Ministry of Health exercises health authority and governance in the region.	Amends RM No. 566-2005/MINSA.
Cajamarca	Regional Executive Resolution No. 729-	ROF formulated in the framework of D.S. No. 043-2006-PCM and R.M. No. 566-2005/MINSA. Organization in accordance to the standardized model	No information	De-concentrated body of the Social Development	No information

Region	ROF	Observations	Roles	Dependency	General Functions
	2003-GR.CAJ/P	approved with R.M. No. 573-2003-SA/DM. Type A.	available	Management.	available
Callao	Ministerial Resolution No. 854-2003-SA/DM dated 07/30/2003	Organization according to the model approved through R.M. No. 573-2003-SA/DM. In this specific case, it considers the Executive Department of International Health as a line organizational branch. Type A.	Not defined	This is the de-concentrated body of the Ministry of Health in the realm of the Constitutional Province of Callao.	Replicates RM No. 573 - 2003
Cusco	Regional Executive Resolution No. 029-2006 dated 01/17/2006	ROF formulated based on the guidelines approved by R.M. No. 566-2005/MINSA, applies almost literally scheme 1 of such resolution. Type B.	Not defined	De-concentrated body of the Social Development Management	Amends RM No. 573 - 2003
Huancavelica	Regional Ordinance No. 148 - 2009 dated 12/29/2009	The ROF of the GR was formulated based on DS No. 043-2006-PCM. Organization amended by the Decentralization process. DIRESA has been included as a line organizational branch of the Regional Government; it only has 5 organic units under its charge. The Departments of Health Networks have passed on to Sub-regional Managements. Type C (2005).	Not defined	The nature of the dependency between DIRESA and GDS is not established. ROF GR establishes functions (listing) without defining the organic structure.	Own
Huánuco	Regional Executive Resolution No. 574-2003 dated 09/26/2003  O.R. No. 058-2009 (ROF Amendment)	The ROF of the GR was formulated based on DS No. 043-2006-PCM and RM No. 566-2005/ MINSA for its preparation (*). Organization according to the standardized model approved through R.M. No. 573-2003-SA/DM. Its organization reflects the changes that were established in the organic structure of MINSA. Incorporates Human Resources and Public Health Intelligence as line organizational branches, forming seven (7) line organizational branches amending the model approved through R.M. No. 573-2003-SA/DM Type C (2003).	Not defined	Line organizational branch of the Regional Management of Social Development from the Regional Government, which by delegation of the Ministry of Health exercises health authority and governance in the region.	Amends RM No. 573 - 2003
Ica	Regional Executive Resolution No. 0235-2004	Does not establish the regulatory framework for the formulation of the ROF. Organization according to the standardized model approved through R.M. No. 573-2003-SA/DM. Type A.	Not defined	Line organizational branch dependent upon the GDG.	Replicates RM No. 573 - 2003
Junín	Regional Ordinance No. 095-2009 dated 05/11/2009	Organization amended. DIRESA has been included as line organizational branch of the Reg. Gov., as Regional Health Management; it only has 7 organic units under its charge. The Departments of Health Networks have been passed on to the Zone Offices.  In January 2011, the Health Management was deleted from the GR flow chart and DIRESA was reinstalled, and by reversing the prior ROF process in force	Not defined	Line organizational branch dependent upon the GDG.	Own

Region	ROF	Observations	Roles	Dependency	General Functions
		(web page), it establishes its organic structure in accordance with the standardized model approved through R.M. No. 573-2003-SA/DM. The legal base establishes RM No. 566-2005/ MINSA for its preparation. Type A.			
La Libertad	Regional Ordinance No. 004-2011 dated 05/3/2011	Counts with an organization approved in the orientations framework established in DS No. 043 -2006 PCM. Type D.	Not defined	Health Management is a line organizational branch of the Regional Government.	Own
Lambayeque	Regional Executive Resolution No. 753-2003 dated 12/31/03	Although it has a 2003 organization, it has not been prepared under the ROF model for DIRESA approved through R.M. No. 573-2003-SA/DM, since the structure of such model is wider. In May 2011, the Health Regional Management was constituted and the Social Development Management was deleted in the structure of the Regional Government. The GRS counts with 17 organic units without establishing their nature or level of dependency. The legal base of the GR ROF does not consider any of the rules (MINSA – PCM) established for their preparation. Prior organization according to R.M. No. 573-2003-SA/DM. Type A.	Defines roles	Health Management is a line organizational branch of the Regional Government.	Own
Lima Province	Regional Ordinance No. 014-2008 dated 03/18/2008	The flow chart of the DIRESA Lima published on the web page of the GR Lima defines an organic structure different from the one established in the ROF. Organization in accordance to R.M. 573-2003-SA/DM. Type A	Not defined	De-concentrated body of MINSA.	Replicates RM No. 573 - 2003
Loreto	R.E.R No. 2049-2009 dated 12/30/2009	The organic structure in force of the DIRESA has been kept with regard to the prior version, the same which reflects one of the models proposed by R.M. N° 566-2005/MINSA, with some variants. The support bodies have been divided, consultancy and line. Type B	No information available		No information available
Madre de Dios	Regional Ordinance No. 015-2008 dated 06/12/2008	ROF formulated in the framework of D.S. N° 043-2006-PCM and RM. N° 566-2005/MINSA. The organic structure amends the standardized model approved with R.M. 573-2003-SA/DM. Creates the Executive Department of Epidemiology, Prevention and Control of Emergencies and Disasters. Type A	Not defined	Line organizational branch dependent upon the GDS.	Replicates RM. No. 566-2005/MINSA.
Moquegua	Regional Ordinance No. 004-2008 dated 12/07/2008	The current organic structure does not consider Consultancy bodies and is based on Supreme Decree N° 043-2006-PCM. Keeps the four executive departments established in the model of RM N° 573-2003-SA/DM and also creates the Executive Department of Human Resources. Type C (2003)	Not defined	<b>De-concentrated line</b> organizational branch of the Regional Government. Exercises the health authority in the region by delegation of the Ministry of Health.	Replicates RM. No. 566-2005/MINSA.

Region	ROF	Observations	Roles	Dependency	General Functions
Pasco	Regional Ordinance No. 172-2008- G.R. PASCO/CR dated 08/15/2008	Amends the model based on R.M. N° 573-2003/MINSA. Two new Organic Units have been included (Office of Public Health Intelligence and the Department of Management and Protection of Health Rights). Type C (2003)	Defines roles	Line organizational branch of the Regional Government. Exercises the health authority in the region by delegation of the Ministry of Health.	Replicates RM. No. 566-2005/MINSA.
Piura	Presidential Resolution No. 859-2004 dated 11/15/2004	Does not define a regulatory framework for the formulation of the ROF. The organic structure amends the standardized model approved through R.M. No. 573-2003-SA/DM. Deletion of the Deputy Director, Advisory Body; the level is raised and the Office of Personnel changes its denomination to Executive Office of Management and HH.RR. Development; the Laboratory of Public Health becomes a line organizational branch, which was previously located as de-concentrated body; new bodies (Legal Consultancy) and organic units are created in line organizational branches Type A.	Not defined	De-concentrated body of the Regional Government. Exercises the health authority in the region by delegation of the Ministry of Health.	Replicates RM No. 573 - 2003
Puno	Regional Ordinance No. 34-2006, dated 06/14/2006	DIRESA has adjusted its organic structure in accordance with R.M. No. 566-2005/MINSA. The Executive Departments of Administration and Planning and Development of Health Systems are defined as line organizational branches. Applies scheme 3 of such resolution. Type B.	No information available		No information available
San Martín	Regional Ordinance No. 027-2009-GRSM/PGR del 09/14/2009	ROF formulated in the framework of D.S. No. 043-2006-PCM. Creates the Executive Department of Integral Health and the Executive Department of Sectorial Health Regulation and Enforcement. Two advisory bodies have been incorporated: Management Commission and Regional Health Council. Type D.	Defines roles	Technical de-concentrated body of the Regional Government.	Own
Tacna	Regional Ordinance No. 021-2008-CR/ dated 12/06/2008	DIRESA has adapted its organic structure within the framework of DS No. 043-2006-PCM and RM No. 566-2005/ MINSA. The Administration and Strategic Planning Executives Offices are defined as line organizational branches (9 line organizational branches). Type C (2005).	Not defined	De-concentrated body of the Regional Government.	Replicates RM. No. 566-2005/MINSA.
Tumbes	Regional Ordinance No. 001-2010/ dated 01/18/2010)	Does not establish a regulatory framework for the formulation of the ROF.  Keeps the four executive departments established in the model of RM No. 573-2003-SA/DM and also creates the Executive Department of Epidemiology. Type A.	Not defined	Decentralized public body with legal status of public right. In the exercise of its functions, it has functional - technical dependency upon the Ministry of Health and financial dependency upon the Regional Government	Own

Region	ROF	Observations	Roles	Dependency	General Functions
				budgetary set.	
Ucayali	Regional Ordinance No. 018-2005-GRU/CR dated 10/28/2005	Organization according to the standardized model approved through R.M. No. 573-2003-SA/DM. Type A.	Not defined		Own

#### 4.1.2.2 Organizational Arrangement of Health Networks

With respect to the processes of organizational arrangement of health networks, it is possible to identify three basic organizational schemes in their respective organization and functions By-laws of twelve DIRESA, in which information has been obtained (see Table No. 12). Thus, a first group of ten regions (Amazonas, Ancash, Arequipa, Huánuco, Ica, La Libertad, Lima, Piura, Tacna and Ucayali) has not made significant arrangements in their organizational structure, maintaining the standardized organizational design established by MINSA in the year 2003<sup>311</sup>, and subsequently ratified in 2005<sup>312</sup>, which establishes the General Management as governing body, the Institutional Control Office, the Institutional Development Office as advisory body, the offices of Management, Statistics and Informatics as support bodies, the health micro-networks as line organizational branches, and hospitals as decentralized branch, with the functions set forth therein. The Regional Government of Huancavelica has established a territorial organization scheme, assigning the health network to a provincial sub-regional management, setting apart their operational management from the DIRESA, but maintaining the same internal organizational units of their networks. Finally, the Regional Government of San Martín has recently approved the reorganization of their health networks in the framework of a similar process of its DIRESA, establishing the following structure: Network Executive Department as a management organic unit, the Management Committee as an advisory unit, the Planning and Health Management office and Information Management office as advisory units, the Resources Management Office as a support unit, the Departments of Individual and Collective Health Care as line organizational units, and the Hospital and Health micro-networks as decentralized organizational units.

Another crucial dimension that has a direct effect on the organization and operation of health networks is the delimitation of their areas of responsibility. We have identified a group of ten regional governments (Apurímac, Cajamarca, Huancavelica, Huánuco, Lima Region, Lambayeque, Loreto, Pasco, San Martín and Ucayali) that have favored the political-administrative adequacy criteria per province, at expense of the access, resolution capacity and population coverage criteria established by the current standard in this regard<sup>313</sup>. Four regions should be added to this group (La Libertad, Moquegua, Piura and Puno), which have a number of health networks very close to the number of provinces. In the remaining twelve regions (Amazonas, Ancash, Arequipa, Ayacucho, Callao, Cusco, Ica, Junín, Madre de Dios, Tacna and Tumbes), a delimitation scheme based on said standard has been maintained, so the number of health networks does not match the provinces, and in the particular case of Callao, it does not match its districts.

What is stated in the preceding paragraph is a direct result of the transference to regional governments of the faculty to delimitate networks and micro-networks within the decentralization process, as can be seen in Table No. 12, than from 111 health networks established in 2003 throughout the national realm, they have become 145 in 2011. The transference of this faculty does not absolve regional governments of compliance with relevant sectorial regulations.

---

<sup>311</sup> Ministerio de Salud: *Aprueban reglamentos de organización y funciones de las direcciones de salud y de las direcciones de red de salud; Resolución Ministerial N° 573-2003-SA/DM*. Lima, 23 de mayo de 2003.

<sup>312</sup> Ministerio de Salud: *Aprueba los Lineamientos para la adecuación de la organización de las Direcciones Regionales de Salud en el marco del proceso de descentralización; Resolución Ministerial N° 566-2005-MINSA*. Lima, 22 de julio 2005.

<sup>313</sup> Ministerio de Salud / Dirección General de Salud de las Personas: *Lineamientos para la conformación de redes de salud. Resolución Ministerial N° 122-2001-SA/DM*. Lima, 26 de febrero del 2001.

**Table No. 12. Evolution of the Number of Networks per Regions**

<b>Region</b>	<b>No. of Networks Recognized by RM 638-2003 SA/DM</b>	<b>No. of Networks Registered by MINSA 2011 (Web portal)</b>
Amazonas	1	4
Ancash	4	6
Apurímac	3	8
Arequipa	6	4
Ayacucho	4	7
Cajamarca	9	14
Callao	3	3
Cusco	4	5
Huancavelica	3	7
Huánuco	3	3
Ica	2	2
Junín	5	6
La Libertad	11	12
Lambayeque	3	3
Lima Region	17	13
Loreto	4	8
Madre de Dios	1	1
Moquegua	1	2
Pasco	2	3
Piura	5	7
Puno	11	11
San Martín	4	10
Tacna	1	1
Tumbes	1	1
Ucayali	3	4
<b>Total</b>	<b>111</b>	<b>145</b>

To favor the political-administrative jurisdiction criteria over the access, resolution capacity and population coverage established by the standard, may mean sacrificing the necessary scale level to enable an efficient management, forcing these health networks to oversize the administrative apparatus in order to manage their resources, or their effectiveness, providing the networks of insufficient human, physical and financial resources for the compliance of its purpose. None of these situations are desirable, and the trend will be towards the irrelevance of networks that do not reach the necessary scale level.

In this regard, it has sought to explore on the administrative abilities of the existing health networks, which usually means having the status of a budget executing unit: While MINSA recognizes 146 health networks nationwide, MEF only counts 65 health networks with executing character (out of a total of 133 health executing units, which include DIRESA and hospitals). Thus, a first group of four regions is identified (Ancash, Cusco, Ica and Junín), which all health networks are executing. In this same group five additional regions can be considered (Arequipa, Ayacucho, La Libertad, Huánuco and Puno) that reach a high proportion of executing health networks. A second group formed by fourteen regions (Apuurimac, Amazonas, Cajamarca, Lambayeque, Lima Region, Loreto, Madre de Dios, Moquegua, Piura, Pasco, San Martín, Tacna, Tumbes and Ucayali) virtually has no health networks with executing unit character. The latter group includes the category of "*functional networks*" as those lacking of the executing condition, and for which this feature is a limiting factor for its adequate operation, as shown in Table No. 13.

**Table No. 13. Characteristics of Functional Networks and Executing Networks per Region, 2011.**

Region	No. of Provinces	Total Health EU	No. of EU Networks	No. of Health Networks	% of EU Networks
Amazonas	7	5	1	4	25.0%
Ancash	20	8	6	6	100.0%
Apuurimac	7	4	1	8	12.5%
Arequipa	8	7	3	4	75.0%
Ayacucho	11	6	4	7	57.1%
Cajamarca	13	6	3	14	21.4%
Callao	1	3	0	3	0.0%
Cusco	13	8	5	5	100.0%
Huancavelica	7	2	0	7	0.0%
Huánuco	11	5	2	3	66.7%
Ica	5	7	2	2	100.0%
Junín	9	9	6	6	100.0%
La Libertad	15	10	8	12	66.7%
Lambayeque	3	3	0	3	0.0%
Lima Region	10	8	3	13	23.1%
Loreto	7	4	1	8	12.5%
Madre de Dios	3	2	0	1	0.0%
Moquegua	3	2	1	2	50.0%
Pasco	3	3	1	3	33.3%
Piura	8	7	2	7	28.6%
Puno	13	11	10	11	90.9%
San Martin	10	4	4	10	40.0%
Tacna	4	2	0	1	0.0%
Tumbes	3	2	0	1	0.0%
Ucayali	4	5	2	4	50.0%
<b>Total</b>	<b>195</b>	<b>133</b>	<b>65</b>	<b>145</b>	<b>44.83%</b>

Source: Ministry of Health. National Registry of Health Networks, 2011.  
Portal – Friendly query, 2011

Ministry of Economy and Finances: SIAF

**Table No. 14: Organizational Characteristics of Health Networks per Region, 2011.**

Region	ROF Approval	Observations
Amazonas	Regional Executive Resolution No. 343-2005-Regional Government of Amazonas/PR, creating the Health Network of Condorcanqui.	Low proportion of health networks with executing unit character. Does not assume the provincial scheme for the delimitation of networks. The Public Health and Health Intelligence Office is established as an advisory body. Micro-networks are established as line organizational branches, and hospitals as decentralized branches.
Ancash	Regional Executive Resolution No. 0220-2006-GRA/PRE – approves the modification of health networks and micro-networks of the Regional Health Directorate of Ancash. Regional Executive Resolution No. 0150-2008-GRA/PRE of 02/21/2008.	High proportion of health networks with executing unit character. Does not assume the provincial scheme for the delimitation of networks. The Institutional Development Office is established as an advisory body, incorporating the Integral Health Office, Health Intelligence Office, Statistics and Informatics Office, Planning and Budget Office. Micro-networks are established as line organizational branches, and hospitals as decentralized branches.
Apurímac	No information on website	Low proportion of health networks with executing unit character. Assumes the provincial scheme for the delimitation of networks.
Arequipa	OR No. 044-CR/GR - 2008	High proportion of health networks with executing unit character. Does not assume the provincial scheme for the delimitation of networks. Organizational unit of the GRS (former DIRESA). The Planning, Budget and Institutional Development Office is established as an advisory body. Micro-networks are established as line organizational branches.
Ayacucho	No information on website	High proportion of health networks with executing unit character. Does not assume the provincial scheme for the delimitation of networks.
Cajamarca	No information on website	Low proportion of health networks with executing unit character. Assumes the provincial scheme for the delimitation of networks.
Callao	No information on website	Assumes a delimitation scheme according to the current standard, not matching its districts.
Cusco	No information on website	High proportion of health networks with executing unit character. Does not assume the provincial scheme for the delimitation of networks.
Huancavelica	OR No. 104-CR/GR - 2007 (ROF GR) OR No. 148-CR/GR - 2009	Assumes the provincial scheme for the delimitation of networks. Operational unit. Line organizational branch of the Sub-regional Management. Grants independence to the

Region	ROF Approval	Observations
	(Amendment)	health network operation of DIRESA.
Huánuco	Regional Ordinance No. 005-2003-GRH, which approves the Regional Government Organization and Functions Rules	High proportion of health networks with executing unit character. RER 740-2011 GRH/PR approves the administrative restructuration, establishing 111 health networks and 77 health micro-networks. Assumes the provincial scheme for the delimitation of networks.
Ica	RER 909-2003-GORE- ICA-PR (ROF) RER 0235-2004-GORE- ICA-PR (Amendment)	High proportion of health networks with executing unit character. Does not assume the provincial scheme for the delimitation of networks The Institutional Development Office is established as an advisory body. Micro networks are established as line organizational branches, and hospitals as decentralized branches.
Junín	No information on website	High proportion of health networks with executing unit character. Does not assume the provincial scheme for the delimitation of networks.
La Libertad	RER 402-06-GR-LL-PRE. (Approves the conformation of health networks) RD No. 1951-2006-GR-LL-GRDS-DRS (ROF)	High proportion of health networks with executing unit character. Assumes the provincial scheme for the delimitation of networks. The Institutional Development Office is established as an advisory body. Micro-networks are established as line organizational branches, and hospitals as decentralized branches. Creates the Technical Office as a line organizational branch.
Lambayeque	No information on website	Low proportion of health networks with executing unit character. Assumes the provincial scheme for the delimitation of networks. OR No. 009-2011 GR.-LAMB./CR, reorganizes the GR, creates sector managements.
Lima Region	OR 02-2008-CR-RL March 2008	Low proportion of health networks with executing unit character. Assumes the provincial scheme for the delimitation of networks. The Institutional Development Office is established as an advisory body. Micro-networks are established as line organizational branches.
Loreto	No information on website	Low proportion of health networks with executing unit character. Assumes the provincial scheme for the delimitation of networks.
Madre de Dios	No information on website	Low proportion of health networks with executing unit character. Does not assume the provincial scheme for the delimitation of networks.

Region	ROF Approval	Observations
Moquegua	No information on website	Low proportion of health networks with executing unit character. Does not assume the provincial scheme for the delimitation of networks. The Institutional Development Office is established as an advisory body. Micro-networks are established as line organizational branches, and hospitals as decentralized branches. Creates the Individual and Collective Health Office as an advisory body, and the International Maritime Health Department as a line organizational branch.
Pasco	No information on website	Low proportion of health networks with executing unit character. Assumes the provincial scheme for the delimitation of networks.
Piura	RER No. 859-2004/GRP – PR, 15.11.04	Low proportion of health networks with executing unit character. Does not assume the provincial scheme for the delimitation of networks. The Institutional Development Office is established as an advisory body. Micro-networks are established as line organizational branches, and hospitals as decentralized organizational branches. Creates the Technical Office as a line organizational branch.
Puno	No information on website	High proportion of health networks with executing unit character. Assumes the provincial scheme for the delimitation of networks.
San Martín	O.R. No. 026-2011-GRSM/CR, October 2011	Low proportion of health networks with executing unit character. Assumes the provincial scheme for the delimitation of networks. The following structure is established: the Network Executive Department; Management Committee as an advisory unit; Planning and Health Management Office and Information Management Office as advisory units; Resources Management Office as a support unit; Departments of Individual and Collective Health Care as organic line units; and Hospitals and Health micro-networks as de-concentrated organic units.
Tacna	O.R. No. 021-2008-CR/GRT	Low proportion of health networks with executing unit character. Does not assume the provincial scheme for the delimitation of networks. The Institutional Development Office is established as an advisory body. Micro-networks are established as line organizational branches.
Tumbes	No information on website	Low proportion of health networks with executing unit character. Does not assume the provincial scheme for the delimitation of networks.
Ucayali	OR No. 018-2005-GRU/CR October 2005	Low proportion of health networks with executing unit character. Assumes the provincial scheme for the delimitation of networks.



## 4.2 Institutional Capacity Building Processes

The Ministry of Health, considering the improvements in the transference process of sectorial functions to regional governments, and based on the training needs assessment<sup>314</sup>, defined for 2006 training and technical assistance activities to strengthen skills of this governmental level in the exercise of the new transferred functions. This activities plan was part of the 2006 Transference Plan of MINSA<sup>315</sup>, though it was not part of the Annual Transference Plan of Sectorial Competencies to Regional Governments - 2006 approved by PCM<sup>316</sup>, which focused only on the transference of sectorial functions. The needs assessment was defined by regional governments from the proposed activities identified by the technical teams of the general directorates and offices, and the OPD of MINSA for the 37 faculties transferred at that time, selecting 8 key themes out of 17:<sup>317</sup>

**Table No. 15: Training Needs of DIRESA, 2006..**

Key Themes in-demand	No. of Regions
Organization and Restructuring of DIRESA	19
Environmental and Occupational Health	18
Preparation of Policies and Coordinated Regional Plans	17
HR Technical Processes	16
Information Management	14
Integral Health Care Model (MAIS) and Primary Health Care Management	13
Incorporation of Rights Approach to Integral Health Policies and Processes	11
Operational and Financial Planning	10

The plan pointed out that the 8 key themes were grouped into three functional blocks, which responded to three types of tasks:

<sup>314</sup> The assessment was defined in the “II national workshop on health decentralization, MINSA – Regional Governments”, held at Lima on September 5th and 6th, 2005, by MINSA.

<sup>315</sup> Ministerio de Salud: *Resolución Ministerial N° 189-2006-MINSA, “Plan de Transferencia Sectorial 2006 del Ministerio de Salud”*. Lima, 15 de marzo de 2011.

<sup>316</sup> Presidencia del Consejo de Ministros: *Aprueban el “Plan Anual de Transferencia de Competencias Sectoriales a los Gobiernos Regionales y Locales 2006”*. Decreto Supremo N° 021-2006-PCM. Lima, 27 de abril de 2006.

<sup>317</sup> Ministerio de Salud: *Resolución Ministerial N° 189-2006-MINSA, “Plan de Transferencia Sectorial 2006 del Ministerio de Salud”*. Lima, 15 de marzo de 2011.

- For governance and management guidance.
- For integral health management.
- For management support.

Finally, it was mentioned that the key themes were disaggregated into specific contents<sup>318</sup>:

**Table No. 16: Training Contents for DIRESA, 2006.**

FUNCTIONAL BLOCK	KEY CONTENTS
GOVERNANCE	<b>Organization and Restructuring of DIRESA</b> <ul style="list-style-type: none"> <li>• National processes and legal framework.</li> <li>• Analysis and diagnosis of the DIRESA organization.</li> <li>• Organizational approaches.</li> <li>• Technical criteria for the restructuring process.</li> <li>• Model analysis.</li> <li>• Procedures to follow in a restructuring process.</li> <li>• Formulation of proposals.</li> </ul>
	<b>Formulation of Regional Health Policies</b> <ul style="list-style-type: none"> <li>• Health Situation Analysis.</li> <li>• National Policies Analysis.</li> <li>• Methodology for policymaking.</li> <li>• Formulation of regional priorities and policies.</li> <li>• Development of agreed regional health plan.</li> </ul>
INTEGRAL HEALTH MANAGEMENT	<b>Environmental and Occupational Health</b> <ul style="list-style-type: none"> <li>• Analysis of environmental health in the region, concepts and guidance.</li> <li>• Diagnosis of environmental and occupational health conditions and problems: Applicable methodologies.</li> <li>• Regional priorities.</li> <li>• Policies and standards to address environmental and occupational health.</li> </ul>
	<b>Integral Health Care Model (MAIS) and Primary Health Care Management</b> <ul style="list-style-type: none"> <li>• Integral Health Care Model – MAIS.</li> <li>• Ways of adapting to regional reality.</li> <li>• Formulation of strategies for the involvement of social actors.</li> <li>• MAIS implementation.</li> </ul>

<sup>318</sup>Idem.

FUNCTIONAL BLOCK	KEY CONTENTS
	<b>Incorporation of Rights Approach to Integral Health Policies and Processes</b> <ul style="list-style-type: none"> <li>• Approaches to integral health management.</li> <li>• Incorporation of rights approach.</li> </ul>
<b>MANAGEMENT SUPPORT</b>	<b>Technical Processes of Human Resources Management</b> <ul style="list-style-type: none"> <li>• Personnel selection, training and performance evaluation.</li> <li>• Social welfare programs.</li> <li>• Inquiries, requests and labor claims.</li> </ul>
	<b>Regional Health Information Analysis</b> <ul style="list-style-type: none"> <li>• Organization and/or coordination of the health information needed for decision-making.</li> <li>• Health information systems.</li> <li>• Health information and communication strategies.</li> </ul>
	<b>Operational and Financial Planning</b> <ul style="list-style-type: none"> <li>• Fiscal year programming.</li> <li>• Monitoring of remittance accountability.</li> </ul>

It should be noted that the MINSA proposal for 2006 was developed having as policy framework the “National Plan for Training and Technical Assistance in Public Management for Strengthening Regional and Local Governments” <sup>319</sup> approved by CND, and the “National Plan for Human Resources Training, Ministry of Health 2005-2006”, prepared by the MINSA’s Institute of Human Resource Development with the objective of guiding, regulating and conducting human resources training and updating to ensure the achievement of competencies for professional and personal development, as well as the rational and efficient use of training funds<sup>320</sup>. However, given that in 2006 there was a change of government in the country, the 2006 Transfer Plan of MINSA was not implemented, and the Ministry only focused on the transference of 37 faculties to the regional governments included in the 2005 Transference Plan.

For 2007, PCM defined enforceable national policies in the matter of decentralization, placing an article that only said “Provide sector-based training to local and regional governments to build and consolidate an appropriate management capacity.”<sup>321</sup> In this context, the Decentralization Secretariat approved a guideline which established the subscription of management agreements among sectors and regional governments in order to join and provide technical assistance for the

<sup>319</sup>Congreso de la República: “Plan Nacional de Capacitación y Asistencia Técnica en Gestión Pública para el Fortalecimiento de los Gobiernos Regionales y Locales” Refrendado por Decreto Supremo N° 021-2004-PCM. Lima, 29 de marzo de 2009.

<sup>320</sup>Congreso de la República: “Define y establece las políticas nacionales de obligatorio cumplimiento para las entidades del gobierno nacional” Decreto Supremo N° 027-2007-PCM. Lima, 25 de marzo de 2007.

<sup>321</sup>Congreso de la República: “Define y establece las políticas nacionales de obligatorio cumplimiento para las entidades del gobierno nacional” Decreto Supremo N° 027-2007-PCM. Lima, 25 de marzo de 2007.

exercise of the transferred functions, including actions of cooperation, coordination and collaboration<sup>322</sup>.

MINSA formulated the 2007 Sectorial Transference Plan<sup>323</sup>, where it proposed a first stage, consisting of virtual graduate diploma courses delivered by regional universities, to whom MINSA would transfer “*e-learning* and blended learning” methodologies, supported by tutors<sup>324</sup>. The graduate diploma course and internships had been programmed to strengthen abilities in 5 of the functions transferred to regional governments:

**Table No. 17: Training Contents for DIRESA, 2007.**

<ul style="list-style-type: none"> <li>• Function b) Develop and implement through consensus the Regional Health Development Plan.               <ul style="list-style-type: none"> <li>○ Graduate diploma course in Health Decentralization and Modernization.</li> <li>○ Graduate diploma course in Health Public Investment Projects.</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• Function c) Promote and implement as a priority activities associated with the promotion and prevention of health.               <ul style="list-style-type: none"> <li>○ Graduate diploma course in Health Promotion.</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• Function e) Organize care and administration levels of state health entities that provide services in the region, in coordination with local governments.               <ul style="list-style-type: none"> <li>○ Graduate diploma course in Management of Administrative Systems.</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• Function f) Organize, implement and maintain health services for prevention, protection, recovery, and rehabilitation in health matters, in coordination with local governments.               <ul style="list-style-type: none"> <li>○ Graduate diploma course in Health Networks Managing.</li> <li>○ Internship in Obstetric and Neonatal Emergencies.</li> <li>○ Internship in Perinatal Technologies.</li> <li>○ Internship in Clinical Laboratory.</li> <li>○ Internship in Hemotherapy Centers and Blood Bank.</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• Function k) Make available to the population useful information on sector management as well as the situation of health infrastructure and services.               <ul style="list-style-type: none"> <li>○ Graduate diploma course in Monitoring and Evaluation of Health Interventions (DEMIS).</li> <li>○ Graduate diploma course in Basic Epidemiology for Networks and Micro-networks.</li> </ul> </li> </ul>

However, according to the 2008 Sectorial Transference Plan of MINSA<sup>325</sup>, none of the actions programmed for 2007 were performed. The document only reports the implementation of specific training activities:

<sup>322</sup>Congreso de la República: “*Define y establece las políticas nacionales de obligatorio cumplimiento para las entidades del gobierno nacional*” Decreto Supremo N° 027-2007-PCM. Lima, 25 de marzo de 2007.

<sup>323</sup>Ministerio de Salud: *Resolución Ministerial N° 187-2007-MINSA que aprueba el “Plan de transferencia sectorial 2007”*. Lima, 28 de febrero de 2007.

<sup>324</sup>Idem.

<sup>325</sup>Ministerio de Salud: *Resolución Ministerial N° 187-2007-MINSA que aprueba el “Plan de transferencia sectorial 2007”*. Lima, 28 de febrero de 2007.

- Course on “Health Decentralization and Modernization”, where 90 regional government officials participated in order to improve their management of the design, implementation and assessment of processes related to institutional and sectorial decentralization of the health field.
- Seminar on “State Acquisitions and Contracts Regulations” for 150 regional government officials in order to update them<sup>326</sup>.

On the other hand, it did not pose any plan for individual or institutional capacity building, merely presenting a list of routine technical assistance activities and actions programmed by MINSA's general directorates and offices.

Meanwhile, in early 2008, PCM created a permanent Multi-Sector Commission for Capacity Building in Public Management of Local and Regional Governments, attached to the PCM, called “Platform”<sup>327</sup>, to which was entrusted to exercise the functions of leading, designing, monitoring and evaluating the implementation of the National Plan for Capacity Building in Public Management and Good Governance in the context of the decentralization process that will take place in the country. The platform was formed by PCM Secretaries of Decentralization and Public Management, representatives of twelve ministries and of other four institutions. The main functions entrusted were:<sup>328</sup>

- Design the National Plan for Capacity Building in Public Management and Good Governance.
- Design capacity-building programs and tools for strategic management.
- Connect training services and technical assistance providers to local demands, with a comprehensive approach to local and territorial development.
- Have a monitoring and evaluation system that enables improving the efficiency of the investments in human resources and institutional capacities.
- Propose assessment and monitoring systems to public management performance in order to maintain sustainable the country's decentralization process.
- Promote the establishment of platforms and regional networks as a space for dialogue, representation and implementation of the national, sectorial and local policy, aimed at favoring the public management capacity-building process of regional and local governments.

From the foregoing description, this Platform should have promoted the strengthening of institutional capacities in regional governments. However, regarding MINSA, its 2009 Sectorial Transference Plan<sup>329</sup> did not mention any specific results, even reducing the section destined to

---

<sup>326</sup>Idem.

<sup>327</sup>Presidencia del Consejo de Ministros: *Decreto Supremo N° 02-2008-PCM que crea la Comisión Multisectorial para el Desarrollo de Capacidades en Gestión Pública de los Gobiernos Regionales y Locales*. Lima, 14 de enero de 2008.

<sup>328</sup>Idem.

<sup>329</sup>Ministerio de Salud: *Resolución Ministerial N° 297-2009-MINSA que aprueba el “Plan de transferencia sectorial 2009”*. Lima, 7 de mayo de 2009.

“Training and Technical Assistance Program that the Sector will perform for the Transference”, to a 2009 Capacity-building Plan for the exercise of health decentralized functions, through modalities of training, technical assistance, as well as monitoring and evaluation.

On the other hand, PCM on its “2009 Annual Plan for the Transference of Sectorial Competencies to Regional and Local Governments”<sup>330</sup> issued several complimentary measure for the development of the decentralization process beyond the transference of functions, noting in Article 8 that for “Building Capacities”, the ministries should formulate and approve their capacity-building plans for the exercise of the competencies and functions transferred. This also provided that these plans should be in accordance with the Basic Plans of Institutional and Managing Capacities-building for the Competencies and Functions Transferred. Finally, it established the implementation of capacity-building plans for the National Government as well as the incorporation of the National Civil Service Authority as a member of the Multi-Sector Committee for Capacity Development in Public Management. However, no specific results are known since MINSA did not approve its 2010 Sectorial Transference Plan.

Meanwhile, in January 2010, PCM approved the “National Plan for Capacity Building in Public Management and Good Governance for Local and Regional Governments”, and further provided that the public and private institutions developing training activities for local and regional governments should coordinate their programs with the objectives of the Plan<sup>331</sup>. In this context and after more than one year of approving the National Plan for Capacity Building, the Decentralization Secretariat of PCM recently established the guidelines and procedures for the formulation, approval, implementation, monitoring and assessment of the sectorial, regional and local capacity-building plans provided<sup>332</sup> in Supreme Decree No. 004-2010-PCM, which approved the National Plan for Capacity Building in Public Management and Good Governance for Local and Regional Governments. As expected, the MINSA Sectorial Transference Plan<sup>333</sup> for 2011 does not consider capacity building under the framework of the new regulation, presenting more general activities without specifying or concretizing any of them.

The same day that the transference plan was approved, MINSA approved the “2010-2014 Agreed Sectorial and Decentralized Plan for Health Capacity Building – PLANSALUD”<sup>334</sup> noting that said document had been formulated considering current regulation, and especially, Supreme Decrees No. 047-2009-PCM, No. 004-2010-PCM, and No. 115-2010-PCM, besides mentioning that said

---

<sup>330</sup>Presidencia del Consejo de Ministros: *Decreto Supremo 047-2009-PCM que aprueba el “Plan Anual de Transferencia de Competencias Sectoriales a los Gobiernos Regionales y Locales del año 2009” y otras disposiciones para el desarrollo del proceso de descentralización*. Lima, 24 de julio de 2009.

<sup>331</sup>Presidencia del Consejo de Ministros: *Decreto Supremo 004-2010-PCM que aprueba el “Plan Nacional de Desarrollo de Capacidades para la Gestión Pública y Buen Gobierno de los Gobiernos Regionales y Locales”*. Lima, 11 de enero de 2010.

<sup>332</sup>Presidencia del Consejo de Ministros: *Resolución de Secretaría de Descentralización N° 154-2011-PCM/SD, que aprueba la Directiva N° 001-2011-PCM/SD: “Directiva general para la formulación, aprobación, implementación, monitoreo y evaluación de los planes de desarrollo de capacidades”*. Lima, 11 de marzo de 2011.

<sup>333</sup>Ministerio de Salud: *Resolución Ministerial N° 175-2011-MINSA que aprueba el “Plan de transferencia sectorial 2011”*. Lima, 15 de marzo de 2011.

<sup>334</sup>Ministerio de Salud: *Resolución Ministerial N° 184-2011-MINSA que aprueba el “Plan sectorial concertado y descentralizado para el desarrollo de capacidades en salud 2010 - 2014”*. Lima, 15 de marzo de 2011.

document was approved by the Intergovernmental Commission on Health (CIGS) in June 2010. However, it should be noted that this plan is not the product of a coordinated work with MINSA general directorates or with regional governments, who demanded on the same session to concretize the institutional capacity building proposal based on the specific needs of each regional government.

#### **4.3 Advances and Limitations of the Institutional Strengthening and Adaptation Process**

Doing a balance of the institutional strengthening and adaptation process occurred in regional governments during the 2002-2011 decentralization process, it is possible to draw the following conclusions:

- Any process of decentralization should lead to an institutional restructuring of the public sectorial management at the different governmental levels. However, in Peru the transference of responsibilities has not been accompanied by the necessary actions of organizational adaptation and strengthening of institutional capacities. Thus, very few regional governments have taken the relevant institutional reforms, with the consequence that with few exceptions, the sectorial organizational architecture is virtually the same as the one existing prior to the decentralization process.
- Most regional governments still maintain the organizational structure inherited from the period prior to the decentralization process for their specialized health technical bodies (DIRESA or GERESA), trying to replicate MINSA's organization, despite having other institutional roles and different functions. The prevailing organizational models focus their institutional mission on the provision of public services and do not relieve the exercise of health authority functions regarding sectorial regulation and enforcement. Moreover, these functions are still assigned to the same organizational units responsible for organizing and managing the public services within their competence, showing a clear conflict of interests in being both judge and party in enforcing sectorial regulation compliance.
- Only a minority of regional governments have undertaken the organizational reforms of their specialized health technical bodies (San Martín in late 2009 and La Libertad in early 2011), in order to explicitly adapt to the decentralization process and exercise the functions transferred during this period, establishing specific organizational designs for this purpose. These reorganization processes, due to the short implementation period, are still incipient.
- On the other hand, some regional governments established institutional reforms in their regional executive body, which had an impact on the organizational location inside DIRESA or GERESA:
  - a) Arequipa, La Libertad, Callao, Lambayeque and Junín converted their regional health directorates (DIRESA) in regional health managements (GERESA), eliminating Social Development regional managements and transforming their health bodies into line organizational branches of the general regional managements. However, in none of the five cases, this modification in the organizational nature has its counterpart in the internal structure of their GERESA, which keep all the advisory and support bodies specific to a decentralized instance. In addition, they retain control of the executing unit of health networks of the department's capital and the control of their de-concentrated organizational branches, not constituting line branches in the practice. Since January 2011, the Junín region has initiated a new reorganization process disabling this model.

- b) San Martín and Apurímac introduced organizational modifications aimed at strengthening more their Social Development regional managements, in order to achieve a management model with territorial base rather than sectorial base.
  - c) Huancavelica adopted in 2010 an organizational design based on sub-regional managements in local provincial realms dependent of the General Regional Management, of multi-sector and decentralized character, incorporating as line organizational branches the different operational units providing services from various sectors, while maintaining the support and advisory bodies of the latter. Thus, sectorial regional directorates are no longer in control of their decentralized divisions.
- Except the experience in Huancavelica with the reordering of budget executing units of their sub-regional managements, and in San Martín with the transference of the executing unit of their DIRESA to the health network in San Martín, the administrative arrangements of the different government levels have not become key points of the institutional adaptation processes.
- With respect to the organizational adaptation processes of health networks, it is concluded that the vast majority (10 of twelve DIRESA with information) have maintained the standard organizational design established by MINSA in 2003, which has a bureaucratic bias of organizational design. The Regional Government of Huancavelica has established a territorial organization scheme, ascribing the health network to a provincial sub-regional management. Meanwhile, the Regional Government of San Martín has recently approved a structure for their health networks in the framework of the reorganization of its DIRESA.
- With regard to the delimitation of their networks, 14 regional governments have favored the political-administrative adaptation criteria per province at expense of the access, resolution capacity and population coverage criteria established by the in force regulation. Twelve have maintained the application of said regulation, so the number of health networks does not match the provinces, and in the particular case of Callao, does not match its districts. However, favoring these criteria can mean to sacrifice the scale level needed to enable an efficient management, which becomes evident when analyzing its administrative capacities: While MINSA recognizes 146 national networks, MEF only counts 65 networks with executing character. Thus, we can identify nine regions reaching a high proportion of executing health networks, whereas fourteen regions have virtually no health networks with executing unit character and with many restrictions for proper operation.
- On the other hand, despite the progress in the process of functions transference to regional governments in the health sector, this has not presented its counterpart in the adaptation and simplification of MINSA. This problem has been due in part to the late approval of the LOPE, almost 5 years later than planned at the beginning of the decentralization process in 2002. But still, it has been almost four years since its enactment, and MINSA has not yet submitted a proposal for a new organization and functions legislation. One could assess the political will there has been to adapt the organization and functioning of MINSA to the decentralization framework.
- In fact, these problems are the result of the general design of the Peruvian decentralization process that conceived it as a simple transference of functions to local and regional governments, along with some individual training actions, giving a subsidiary character to the other components of the process, including the organizational adaptation and the strengthening

of institutional capacities. This was established by the Decentralization Bases Law, by confining it to a training plan during the preparatory stages, as well as the constitution the regional and local governments<sup>335</sup>.

- Subsequently, the accreditation law<sup>336</sup> arranged to provide training and technical assistance to public management at regional and local governments. Likewise, it established that regional governments should have institutional development plans and basic plans of institutional capacity-building and of competencies and functions management, as well as manuals of organization and functions developed according to the requested competencies. Nevertheless, these documents turned out to be only bureaucratic requirements.
- Only in 2009, the Decentralization Secretariat of the PCM proposed the development of decentralized management models<sup>337</sup>, but of very slow formulation and implementation in the different sectors.
- Another important gap in the design of the decentralization process has been the necessary adaptation of administrative systems of public management, highly centralized and focused in the control of procedures and budget implementation. The administrative systems<sup>338</sup> are sets of principles, standards, procedures, techniques, and instruments that organize the public administration activities required to be made by all or several State entities, in order to regulate the use of its resources, promoting efficiency and effectiveness in its use<sup>339</sup>. Thus, the bases law<sup>340</sup> as well as the organic law of regional governments only provide the strengthening of administrative systems for budget, personnel, treasury, accounting, credit, contracting and procurement, and public investment, but not its adaptation to the new legal framework of competencies distribution. The only systems that have had certain adaptation levels have been the investment and budget planning, although the latter with certain centralist bias.

These findings show a very incipient situation of institutional adaptation at various governmental levels and in the health sector with respect to the new decentralization framework. In fact, until 2010, the only experience that had effectively addressed the comprehensive reform of a regional directorate was the case of San Martín and its DIRESA<sup>341</sup>, when separating its administrative headquarters of its territorial operational units (health networks), to focus it in its management role

---

<sup>335</sup> Congreso de la República: *Ley de bases de la descentralización*; Ley N° 27783. Lima, 17 de julio del 2002. Segunda disposición transitoria.

<sup>336</sup> Congreso de la República: *Ley del sistema de acreditación de los gobiernos regionales y locales*; Ley N° 28273. Lima, 16 de junio de 2004. Art. 6, 7 y 9.

<sup>337</sup> Presidencia del Consejo de Ministros / Secretaría de Descentralización: *Plan anual de transferencias sectoriales a los gobiernos regionales y locales del año 2009*; Decreto Supremo N° 047-2009-PCM. Lima, 23 de Julio de 2009.

<sup>338</sup> The national systems on strategic planning, budget, treasury, accounting, public procurement and State contracting, human resources management, public investment, data processing and control.

<sup>339</sup> Congreso de la República: *Ley Orgánica del Poder Ejecutivo*; Ley N° 29158. Art. 43° y 46°. Lima, 20 de diciembre de 2007.

<sup>340</sup> Congreso de la República: *Ley de bases de la descentralización*; Ley N° 27783. Segunda disposición transitoria.

<sup>341</sup> Raul Molina's report also refers the experiences of regional directorates of Education in La Libertad and Arequipa, but qualifies them as partial.

of the regional sectorial policy, without changing its name or organizational level.<sup>342</sup> However, this experience that is taking place since late 2009 has a partial implementation level. The reorganization of La Libertad's GERESA is just about to begin its implementation. Limiting and facilitating factors in the organizational adaptation process: Human resources, incorporation of managers, budget unit arrangements, etc.

In this regard, it is important to try identifying the factors that limit the design, approval and implementation of the organizational adaptation processes:

- Factors associated with the organizational design easily require the absence of this component in the decentralization policy, which results in the lack of technical assistance to regional governments by the PCM (both by its SGP as its SD). Similarly, the shortage of human resources with the skills required for preparing organizational designs within regional governments and DIRESA; those existing are usually only trained in the preparation of management documents but not in organizational design. This explains that the organizational developments carried out by regional governments as by directorates or regional health managements have certain methodological limitations: a) The institutional roles are not specified<sup>343</sup>; b) there are inconsistencies in the characterization of the nature of organic instances; c) there are no organizational designs based on precise organizational specialization criteria, but rather diffuse identification guidelines of organic units outside a systematic methodology for organizational design.
- With respect of the approval of proposals for institutional reforms by regional governments, the limiting factors are associated in some regions with the insufficient understanding of its nature as governmental bodies and their responsibilities in the implementation of policies for social sectors. Also, the limited coordination between regional managements and DIRESEs hinders the design of coherent proposals that include both levels. On the other hand, in those regional governments that have undertaken organizational changes, not enough importance has been given to the necessary coordination between the proposals for institutional reform of its executive bodies and sectorial regional directorates. There is not enough understanding of the need for comprehensive reforms, also at the managerial level, as well as of its specialized sectorial technical bodies and in the public services operational bodies<sup>344</sup>.
- Finally, regarding the limiting factors in implementing institutional reforms, we may find the shortage of specialized personnel in the existing human resources to form the new organic units, difficulties in recruiting due to restrictions in procedures, budget, labor market, or level of salaries offered. Another element is the difficulty of implementing the necessary budget units' arrangements for alignment with organizational changes, which are subordinated to MEF. We must also indicate the difficulties inherent in any organizational change in relation to the uncertainties and resistances generated in human resources, which may have consequences in the reaction of unions before the change. Likewise, the limited articulation between the regional managements and DIRESA impedes the changes needed for administrative procedures, whose regulation corresponds to the first ones. On the other hand, in those

---

<sup>342</sup> Molina, R. 2010. Op. cit.

<sup>343</sup> Out of 21 regional governments with access to their organization and functions rules, only Pasco, San Martín and Lambayeque have specified the institutional roles of their DIRESA and their corresponding bodies.

<sup>344</sup> Molina, R. 2010. Op. cit.

regions that have undertaken organizational changes, the design of strategy and implementation plans have not been given importance as well as the management of the same change. In addition, it is necessary to indicate the resistances before changes in DIRESA, which are generated in the different organic units of MINSA, used to having their corresponding counterparts in the regions and to a centralist culture accentuated by the absence of the necessary reorganization of MINSA, in order to adapt to the decentralization process. Finally, this present failure to adapt in the diverse organic units of MINSA brings as a consequence the emission of national regulation opposite to decentralization, and that invades the realms of regional competence<sup>345</sup>.

Ultimately, it is necessary to reflect on the extent of the necessary political and administrative autonomy to address the public health problems in their respective realm, instituted with the process of decentralization. This autonomy should allow regional governments to formulate, implement and control specific regional public policies aimed at addressing their regional public health priorities. This certainly implies to set aside nationally uniform and centralist technical designs for new public health management decentralized models, focusing on results. A health priority constitutes a particular health public problem in a determined territory, seeking its effective control through an analysis of the own causes that determine it (considering the specific social, cultural and geographical conditions of each region), as well as the design and implementation of specific comprehensive and synergic interventions, composed of individual health care and collective interventions focused on the control of their causes, whether these are environmental conditions or population behavior. This autonomy requires developing flexible administrative mechanisms that facilitate the implementation of regional health policies, such as programming procedures for the required budget, payment mechanisms, monitoring and supervision systems, among others.

In this sense, it is important to analyze whether the modifications performed in the budget programming process would facilitate the autonomous development of regional policies. These changes were established since 2008 through the so-called “*budget by results*” or PpR<sup>346</sup>, which aimed “*to achieve that the budgetary process drives and develops a results-based management in the Peruvian State,*” through “*strategic programs.*” These were defined as coordinated interventions of the State, among sectors and the three governmental levels around solving a problem that was affecting the population, designed based on a *Logical Model* that enables the generation of products and the achievement of results.<sup>347</sup> The aim was to use a strategic budget programming, the establishment of goals, activities and indicators, follow-up of results with performance indicators (of independent evaluation)<sup>348</sup>. In this sense, the PpR is only a mechanism of budgetary allocation

---

<sup>345</sup> Arguedas, Cinthya Arguedas: *Revisión y análisis del marco normativo vigente según las funciones transferidas en el marco del proceso de descentralización*. PARSALUD II. Lima, junio de 2010.

<sup>346</sup> Congreso de la República: *Ley de Presupuesto del Sector Público para el año 2007*; Ley 28927. Lima, 30 de noviembre de 2006.

<sup>347</sup> Ministerio de Economía y Finanzas / Dirección Nacional del Presupuesto Público: *Directiva N° 010-2007-EF/76.01 para la programación y formulación del presupuesto de los programas estratégicos en el marco del presupuesto por resultados*. Lima, 2007.

<sup>348</sup> Congreso de la República: *Ley de Presupuesto del Sector Público del Año Fiscal 2009*; Ley 29289. Lima, diciembre de 2008.

that seeks reaching results to solve *national problems*, being the ministries responsible for their formulation.

Nevertheless, budget programming procedures are not enough; it is necessary to have planning processes based on results and agreed on between the different actors, which define specific implementation plans where it is specified who, how, when and with what resources the activities will be performed. Thus, the usefulness of the PpR has as a condition to be sustained on a *decentralized results-based management model*, installed in regional and local governments. This can only be achieved through the institutional reform processes of regional and local governments, and not with the simple implementation of budget programming mechanisms. Rather, the PpR implementation has served to strengthen the former model of vertical health programs management.

## 5. Conclusions of Health Institutional Decentralization

### 5.1 Results of Health Institutional Decentralization

- 6 Decentralization aims to improve the performance of the country's governmental apparatus at its different governmental levels, in order to achieve actions more suited to the needs of citizens throughout the country. The current decentralization process in the health sector has been focused on the transference of responsibilities to regional governments. In this sense, it is expected that these will achieve higher performance levels in the exercise of the functions and powers that they have received. Unfortunately, there is no baseline respect to the stage prior to the transference, but a measurement on the exercise of these functions was performed nationwide in the period 2008 – 2009 (see Table No. 19), and there is in advance a second measurement in 2011, although only in seven regions. It should be noted that the instrument used for this measurement is specific regarding the functions and faculties transferred to regional governments.
- 7 For this purpose, the health management processes have been differentiated according to their nature: a) *core or essential processes*, which are directly related to the purpose of the sector; b) *conduction processes*, which lead the health management and correspond to Policy Issues, Strategic and Operational Planning, and Institutional Organization; c) *support processes*, those which provide support services or the necessary resources to comply with the institutional purpose, and that includes the Supply of Medications, Research Management, Investment Management, Public Insurance Management, Financial Resources Management, and Institutional Management of Human Resources. The core processes are further divided according to the nature of their public health services (risk and damage management, organization of health services, supply of medications, health promotion), and to government regulatory actions as well as public and private sector enforcement (sectorial regulation and enforcement of Medications, Environmental Health, Human Health, and Human Resources).
- 8 First, it is observed that the general average was 35% of performance for all processes in the 24 regional governments measured, i.e. a relatively low value. When performing the analysis per type of process, it is necessary to perform it first regarding the ones that are essential, which represent the purpose of the sector, for which the average value corresponds to 36% of performance, also a relatively low value. If the core processes are disaggregated per nature, there is an average of 30% for sectorial regulation processes and of 44% for public services providers, being this difference expected in the measure that the sector, and especially health directorates, have favored in the past their role as service providers. Likewise, in the balance of organizational adaptation of the previous chapter, it has been shown that DIRESA have not made adaptations or arrangements to these to assign and exercise sectorial regulation functions, with few exceptions; in the same manner, national and regional measures to promote institutional capacity development related to their exercise have been extremely limited.
- 9 Among the processes of public service provision, the highest value corresponds to risk and damage management with 48%, followed by health promotion with 47%, and finally the organization of health services with 36%. The average of the risk and damage management process seems to be explained by the instrumental nature of the transferred functions rather than by the results obtained when facing disasters; while the low level obtained by the organization of health services would express a major limitation in regional governments to

organize their hospitals, health networks and micro networks. The latter has been evident in the balance of the organizational adaptation of health networks in the previous chapter.

- 10 On the other hand, it should be noted that among the sectorial regulation and enforcement processes there is a clear difference in the performance of the medication regulation and enforcement process (44%) compared to others in this group (29% in medications, 29% in human health and 17% in human resources), being the most incipient the sectorial regulation and enforcement of human resources with 17%. To further deepen this analysis, we have sought the results achieved by the health sectorial regulation and enforcement process for people in specific registration, classification and monitoring sub-processes of public and private health facilities, as shown in Table No. 18. It should be noted that it has been assumed that the universe of existing facilities is the one registered by municipalities at the time of granting the operating licenses, an assumption that ignores those informal facilities working without a license. It is noted that only 66% of the existing facilities in the country are registered in the National Registry of Health Facilities of MINSA, while only about half (53%) have established their complex category, and only 13% have been monitored for compliance with the standards set by the sector. It was also noted that 295 health facilities (EESS) (1.6%) were temporarily or permanently closed during 2011. The sub-process with higher weakness is the inspection of facilities, with very low coverage; only the regions of Lima, Junín, La Libertad, Tacna and Madre de Dios perform these operations on a more regular basis, whereas in others they are virtually not performed. On the other hand, the actions for closing health facilities are also performed on a limited basis in most regions. These data cast doubt on the effectiveness and usefulness of this process to ensure the proper operation of public and private health services, in order to guarantee their efficiency, safety and quality for the citizens who use them.

**Table No. 18: Coverage of Sectorial Regulation and Enforcement Actions of Health Services (HS)**

Region	Inspection to HS		Closing of HS		HS registered		HS in RENAES 2011		Total HS in RENAMU 2010
	Nº	%	Nº	%	Nº	%	Nº	%	
Amazonas	0	0.0%	1	0.2%	457	86.7%	468	88.8%	527
Ancash	0	0.0%	16	2.2%	435	60.8%	490	68.5%	715
Apurímac	0	0.0%	1	0.2%	357	77.9%	367	80.1%	458
Arequipa	0	0.0%	2	0.2%	265	29.8%	538	60.6%	888
Ayacucho	2	0.4%	41	7.5%	396	72.0%	434	78.9%	550
Cajamarca	0	0.0%	8	0.6%	853	68.2%	884	70.7%	1,250
Callao	2	0.5%	40	10.5%	220	57.6%	475	124.3%	382
Cusco	2	0.2%	11	1.3%	308	35.1%	394	44.9%	878
Huancavelica	1	0.2%	5	1.2%	401	98.0%	422	103.2%	409
Huánuco	0	0.0%	1	0.3%	281	84.1%	282	84.4%	334
Ica	0	0.0%	2	0.5%	184	42.8%	227	52.8%	430
Junín	203	20.4%	25	2.5%	509	51.1%	616	61.8%	997
La Libertad	74	10.8%	3	0.4%	367	53.5%	439	64.0%	686
Lambayeque	0	0.0%	5	1.3%	227	57.9%	345	88.0%	392

Region	Inspection to HS		Closing of HS		HS registered		HS in RENAES 2011		Total HS in RENAMU 2010
	Nº	%	Nº	%	Nº	%	Nº	%	
Lima	2,108	37.4%	464	8.2%	2,154	38.2%	3,000	53.3%	5,633
Loreto	1	0.2%	10	2.0%	394	80.4%	401	81.8%	490
Madre De Dios	38	21.6%	13	7.4%	121	68.8%	156	88.6%	176
Moquegua	2	1.7%	1	0.9%	61	52.6%	62	53.4%	116
Pasco	0	0.0%	14	4.1%	264	77.0%	293	85.4%	343
Piura	0	0.0%	4	0.5%	414	52.4%	504	63.8%	790
Puno	1	0.1%	13	1.7%	465	61.0%	542	71.1%	762
San Martín	4	0.7%	5	0.9%	370	65.6%	378	67.0%	564
Tacna	27	11.3%	0	0.0%	95	39.6%	132	55.0%	240
Tumbes	0	0.0%	1	1.0%	52	52.5%	69	69.7%	99
Ucayali	0	0.0%	3	0.8%	211	58.1%	240	66.1%	363
<b>Total general</b>	<b>2,465</b>	<b>13.3%</b>	<b>295</b>	<b>1.6%</b>	<b>9,861</b>	<b>53.4%</b>	<b>12,158</b>	<b>65.8%</b>	<b>18,472</b>

(\*)Percentage calculation for inspections, closings and registrations was made taking the total EESS recorded in the database of RENAMU. The rest of the information corresponds to RENAES.

It is pertinent to note that MED has set for the health services monitoring sub-process a low qualification when it has not reached a 40% coverage, which has not been achieved by almost all regional governments. In the case of the Madre de Dios region, this function is registered as not performed, although it is one of the regions with the highest number of inspections and closings of health facilities reported.

In addition, regarding the institutional conduction processes, an average value of 41% is observed, corresponding 44% to policies emissions, 40% for strategic and operational planning, and 37% to institutional organization. These results are expected, to the extent that with the conformation of regional governments in January 2003, is when they are granted political and administrative autonomy, while in the previous period all of these processes were direct responsibility of MINSA.

Finally, in relation to support functions, the average is 32%, corresponding the highest degree of exercise to investment management (49%), followed by supply of medication (40%), compared with the other processes. The result in investment management can be linked to the implementation of the “*investments shock*” of 2007 and 2008 (whereas this measurement was made in late 2008 and early 2009). On the other hand, the low level performance for research management (7%) calls the attention, as it is actually present almost exclusively in Arequipa, Callao, Lima, Tacna, La Libertad and Loreto, with values over 10%; although this result is predictable to the extent that it was not a function exercised by health directorates.

Table N° 19: Monitoring results of health decentralization (MED Salud), 2008 – 2009.

PROCESSES	AMAZONAS	ANCASH	APURIMAC	AREQUIPA	AYACUCHO	CAJAMARCA	CALLAO	CUSCO	HUANCABELICA	ICA	JUNÍN	LIMA	MADRE DE DIOS	MOQUEGUA	PIURA	PUNO	SAN MARTÍN	TACNA	TUMBES	UCAYALI	HUÁNUCO	PASCO	LA LIBERTAD	LORETO	AVERAGE
<b>ESSENTIAL PROCESSES</b>	31%	32%	40%	36%	47%	24%	43%	39%	23%	33%	33%	63%	31%	32%	29%	34%	36%	39%	43%	37%	30%	20%	49%	34%	36%
<b>Sectorial Regulation Processes</b>	28%	26%	34%	25%	36%	20%	39%	31%	18%	24%	22%	63%	20%	23%	29%	31%	32%	45%	33%	32%	23%	17%	36%	30%	30%
Regulation of Medications	43%	43%	41%	28%	65%	33%	44%	55%	26%	31%	45%	93%	28%	35%	47%	44%	54%	71%	53%	33%	34%	32%	44%	38%	<b>44%</b>
Regulation of Environmental Health	24%	23%	28%	34%	30%	22%	60%	11%	16%	21%	11%	82%	26%	13%	23%	26%	38%	28%	16%	39%	25%	24%	50%	26%	<b>29%</b>
Regulation of Human Health	32%	29%	36%	21%	40%	15%	36%	25%	22%	25%	14%	33%	18%	22%	33%	40%	32%	47%	40%	25%	22%	4%	43%	43%	<b>29%</b>
Regulation of Sectorial Human Resources	12%	8%	29%	16%	8%	8%	16%	33%	8%	20%	16%	45%	8%	21%	12%	12%	4%	33%	21%	29%	12%	8%	8%	12%	<b>17%</b>
<b>Service Provision Processes</b>	35%	40%	48%	52%	63%	29%	48%	50%	30%	44%	49%	62%	45%	45%	29%	38%	40%	32%	58%	44%	40%	24%	66%	39%	44%
Risk and Damage Management	35%	44%	56%	62%	53%	32%	48%	62%	33%	53%	65%	62%	47%	53%	35%	41%	43%	38%	56%	50%	47%	28%	68%	44%	<b>48%</b>
Organization and Management of Health Services (SS)	37%	30%	37%	32%	53%	19%	40%	37%	29%	26%	24%	60%	45%	32%	31%	40%	37%	34%	44%	48%	31%	18%	62%	27%	<b>36%</b>
Health Promotion	33%	46%	50%	61%	83%	37%	56%	50%	28%	54%	59%	65%	44%	50%	21%	33%	41%	25%	74%	33%	41%	25%	69%	46%	<b>47%</b>
<b>CONDUCTION PROCESSES</b>	38%	45%	27%	36%	58%	33%	45%	40%	22%	48%	38%	70%	51%	23%	28%	37%	34%	54%	43%	34%	30%	25%	60%	56%	41%
Policy Issues	41%	46%	25%	51%	84%	43%	49%	46%	28%	59%	38%	59%	50%	24%	38%	42%	29%	33%	54%	38%	37%	33%	73%	42%	<b>44%</b>
Strategic and Operational Planning	35%	68%	20%	29%	43%	29%	33%	32%	20%	58%	38%	87%	56%	29%	28%	33%	43%	60%	38%	26%	41%	17%	43%	60%	<b>40%</b>
Institutional Organization	37%	21%	37%	28%	46%	28%	52%	41%	19%	28%	37%	65%	46%	16%	19%	37%	29%	69%	37%	37%	12%	24%	63%	65%	<b>37%</b>

PROCESSES	AMAZONAS	ANCASH	APURIMAC	AREQUIPA	AYACUCHO	CAJAMARCA	CALLAO	CUSCO	HUANCAVELICA	ICA	JUNÍN	LIMA	MADRE DE DIOS	MOQUEGUA	PIURA	PUNO	SAN MARTÍN	TACNA	TUMBES	UCAYALI	HUÁNUCO	PASCO	LA LIBERTAD	LORETO	AVERAGE
<b>SUPPORT PROCESSES</b>	30%	36%	36%	30%	36%	21%	48%	27%	17%	34%	33%	62%	36%	23%	29%	24%	23%	43%	35%	32%	21%	19%	51%	33%	32%
Supply of Medications	41%	44%	48%	37%	61%	25%	37%	55%	17%	35%	44%	79%	28%	34%	41%	28%	34%	49%	61%	28%	30%	24%	54%	28%	<b>40%</b>
Research Management	0%	0%	4%	23%	0%	0%	23%	0%	0%	8%	8%	15%	0%	4%	8%	0%	0%	13%	4%	0%	0%	4%	25%	20%	<b>7%</b>
Investment Management	33%	88%	53%	21%	47%	33%	100%	33%	29%	62%	38%	85%	73%	24%	56%	38%	34%	77%	33%	57%	44%	25%	56%	25%	<b>49%</b>
Public Insurance Management	33%	53%	38%	29%	41%	21%	37%	23%	12%	25%	35%	41%	38%	19%	28%	22%	25%	51%	26%	27%	4%	12%	44%	71%	<b>31%</b>
Financial Resources Management	35%	26%	37%	28%	44%	32%	43%	24%	19%	40%	28%	63%	40%	16%	19%	17%	25%	43%	32%	15%	18%	24%	69%	38%	<b>32%</b>
Physical Resources Management	48%	21%	40%	31%	28%	19%	40%	35%	36%	38%	24%	77%	34%	24%	45%	26%	34%	29%	40%	48%	3%	18%	73%	34%	<b>35%</b>
Human Resources Institutional Management	21%	17%	30%	23%	19%	14%	46%	18%	5%	17%	39%	75%	34%	18%	14%	28%	9%	40%	32%	37%	30%	14%	40%	26%	<b>27%</b>
Information Management	30%	39%	41%	44%	48%	26%	54%	31%	15%	48%	45%	60%	40%	46%	23%	36%	20%	45%	48%	40%	39%	33%	43%	25%	<b>38%</b>
<b>TOTAL AVERAGE</b>	<b>32%</b>	<b>36%</b>	<b>36%</b>	<b>33%</b>	<b>44%</b>	<b>24%</b>	<b>45%</b>	<b>34%</b>	<b>20%</b>	<b>36%</b>	<b>34%</b>	<b>64%</b>	<b>36%</b>	<b>27%</b>	<b>29%</b>	<b>30%</b>	<b>30%</b>	<b>44%</b>	<b>39%</b>	<b>34%</b>	<b>26%</b>	<b>20%</b>	<b>52%</b>	<b>37%</b>	<b>35%</b>

## 5.2 Limitations of Health Institutional Decentralization

The results show poor governmental performance in the health sector of regional governments, due to multiple limitations of the health decentralization process, despite being one of the sectors that have shown major advances:

- In general terms, the decentralization process has been almost exclusively limited to the transference of functions, with a partial transference of financial resources related to their exercise, but without the corresponding sectorial regulation adaptation needed to adjust to the new context of decentralization, and lacking the transference or development of the corresponding operational tools.
- This transference of responsibilities has occurred without the proper division of competences and functions between the three governmental levels, lacking until now of the precise identification of national and local functions.
- Moreover, according to the balance performed, there were few modifications in the organizational adaptations of the three governmental levels, especially at national and local levels. Although few regional governments have undertaken institutional reforms of their executing bodies, they are far from being significant processes with a real impact in their governmental performance. Specifically in the health sector, almost all directorates or regional managements have maintained the standard organizational design prior to the decentralization process and established in cross-current by MINSA in 2003. Some modifications have been made, not with the purpose of exercising the functions and powers transferred, but rather to replicate the exuberant organizational structure of MINSA, despite having a different role and different functions. Only the San Martín DIRESA in late 2009 and La Libertad earlier this year have undertaken reorganization processes supported by specific organizational designs for the functions they have received, but still with an incipient implementation. IN MINSA no adaptation to the new roles and functions have taken place, resulting from the transference of several of their previous functions to regional governments, but rather it has deepened its exuberance and fragmented organizational structure.
- On the other hand, several limiting factors for the implementation of the institutional reforms required have been identified: a) The shortage of skilled personnel among the existing human resources to form new organic units; b) difficulties in their recruitment due to procedure, budget, labor market restrictions, or the level of salaries offered; c) difficulty to implement the necessary budget unit's arrangements for their alignment with organizational changes, which are subordinated to MEF; d) the lack of adaptation of the national administrative system of public management, highly centralized and focused on the control of procedures and budget execution, which have been an important gap in the design of the Peruvian decentralization process.
- Finally, the balance of the institutional capacities-strengthening process shows very important limitations, with the development of very few actions, focused exclusively on training processes, which have not been formulated to meet the specific needs of each region.

### 5.3 Outstanding Subjects of the Health Institutional Decentralization Process

In this sense, there remain several outstanding subjects in the health decentralization process to be addressed in the medium term:

- Complete the matrices of competencies delimitation and functions distribution between the different governmental levels so as to clearly specify the areas of competency and eliminate the duplication of functions.
- Adapt the systems and procedures of public management to the decentralization process, in order to enable the real political and administrative autonomy of the different levels of government.
- Update the Organic Law of Functions (LOF) of MINSA in order to define its national governing role and functions, setting aside the functions transferred to regional governments.
- Adapt the organization of MINSA based on its new roles and functions, simplifying its size but strengthening its institutional capacity to properly exercise its national governance.
- Adapt the national administrative systems of public management, whose responsibility corresponds to the national government as a whole.
- Adapt the decentralized management model, based on the challenges identified.
- Develop institutional strengthening plans for MINSA and the regional governments, which must be performed from measuring the exercise of health functions.
- Execute the transference of functions to the Metropolitan Municipality of Lima as the regional government of the province of Lima.
- Execute the sectorial regulation adaptation in order to facilitate the exercise of the functions transferred to regional governments.
- Strengthen the intergovernmental coordination for developing national sectorial policies, to guarantee their implementation, as well as monitoring and evaluating them.
- Adapt the DIRESA or GERESA organization as part of the redesigning of the Regional Government, for an effective multi-sector social action.
- Strengthen the regional institutional capacities for the exercise of the functions transferred.
- Review the local decentralized health model based on the capabilities of different types of municipalities.
- Specify the local management model to include the participation of local governments in the management of networks and micro-networks.

## Annex: Bibliography

Arguedas, Cinthya: Revisión y análisis del marco normativo vigente según las funciones transferidas en el marco del proceso de descentralización. PARSALUD II. Lima, junio de 2010.

Banco Mundial / Ministerio de Salud / Ministerio de Economía y Finanzas: Ayuda memoria de la misión de evaluación del Proyecto de apoyo a la modernización del sector salud en el Perú. Lima, noviembre de 1998.

Bardález, C. y Ugarte, Ó.: Mapa concertado de competencias y proceso de transferencia de funciones en la descentralización del sector salud. The Partners for Health Reformplus Project, Abt Associates. Lima, febrero de 2005.

Bardález, C.: Guía Metodológica del Mapa Concertado de Competencias en Salud. Promoviendo alianzas y estrategias, Abt Associates Inc. Lima, julio de 2006.

Bardález, C.: Sistematización de los modelos de gestión de recursos humanos en redes básicas de servicios de salud. Informe de consultoría. Organización Panamericana de la Salud. Lima, julio del 2002.

Bardález, C.; Gaillour, A.; Güesmez, Ana: Evaluación rápida sobre la provisión de los servicios de salud en el Perú. Informe Final de consultoría. DFID. Lima, septiembre del 2002.

Bardález, Carlos: Avances en el desarrollo de redes de salud. En: Gaillour, A. y col: Línea de base de la reforma y modernización del sector salud de Perú y su aplicación en el ámbito de intervención del proyecto AMARES. Lima, 2003.

Bardález, Carlos: Avances en la formulación de un marco legal de descentralización de redes y servicios. En: Gaillour, A. y col: Línea de base de la reforma y modernización del sector salud de Perú y su aplicación en el ámbito de intervención del proyecto AMARES. Lima, 2003.

Bardález, Carlos: Avances en la reestructuración y modernización del MINSA. En: Gaillour, A. y col: Línea de base de la reforma y modernización del sector salud de Perú y su aplicación en el ámbito de intervención del proyecto AMARES. Lima, 2003.

Bardález, Carlos: Políticas y planes para la definición e implantación del modelo de atención. En: Gaillour, A. y col: Línea de base de la reforma y modernización del sector salud de Perú y su aplicación en el ámbito de intervención del proyecto AMARES. Lima, 2003.

Brinkerhoff, Derick y Leighton, Charlotte: Nueva perspectiva para los ejecutores: Descentralización y reforma del sistema de salud. Partners for Health Reformplus. Septiembre de 2002.

Brito, P.: Salud, Nutrición y Población en el Perú. En: Población y Políticas de Desarrollo en el Perú. Instituto Andino de Estudios en Población y Desarrollo. Lima, 1983.

Cohen, John; and Peterson, Stephen: Methodological issues in the analysis of decentralization.

Congreso de la República: Aprueban lineamientos para la elaboración y aprobación del Cuadro para Asignación de Personal - CAP de las Entidades de la Administración Pública. Lima, 17 de junio de 2004.

Congreso de la República: Decreto Supremo N° 068-2006-PCM, Establecen disposiciones relativas a la culminación de la transferencia programadas a los gobiernos regionales y locales. Lima, 13 de octubre de 2006.

Congreso de la República: Ley de Bases de la Regionalización; Ley N° 24650. Lima, 19 de marzo de 1987.

Congreso de la República: Ley marco de modernización de la gestión del Estado; Ley N° 27658. Lima, 17 de enero del 2002.

Congreso de la República: Ley N° 27657; Ley del Ministerio de Salud. Lima, 29 de enero del 2002.

Congreso de la República: Ley de modificación constitucional del capítulo XIV título IV sobre descentralización; Ley N° 27680. Lima, 6 de marzo de 2002.

Congreso de la República: Ley de bases de la descentralización; Ley N° 27783. Lima, 17 de julio del 2002.

Congreso de la República: Ley Orgánica de los Gobiernos Regionales; Ley N° 27687. Lima, 16 de noviembre del 2002.

Congreso de la República: Ley de presupuesto del sector público para el año fiscal 2003; Ley N° 27879. Lima, 13 de diciembre de 2002.

Congreso de la República: Ley N° 27902, ley que modifica la Ley Orgánica de los Gobiernos Regionales N° 27687 para regular la participación de los alcaldes provinciales y la sociedad civil en los gobiernos regionales y fortalecer el proceso de descentralización y regionalización. Lima, 1° de enero del 2003. Cuarta disposición transitoria.

Congreso de la República: Ley orgánica de municipalidades; Ley N° 27972. Lima, 27 de mayo del 2003.

Congreso de la República: Ley del Sistema de Acreditación de los Gobiernos Regionales y Locales; Ley N° 28273. Lima, 8 de julio de 2004.

Congreso de la República: Reglamento de la Ley N° 28273 - Ley del Sistema de Acreditación de los Gobiernos Regionales y Locales; aprobado por Decreto Supremo N° 080-2004-PCM. Lima, 15 de noviembre de 2004.

Congreso de la República: Ley de Presupuesto del Sector Público para el año 2007; Ley 28927. Lima, 30 de noviembre de 2006.

Congreso de la República: Ley que regula el régimen transitorio de las direcciones regionales sectoriales de los gobiernos regionales; Ley N° 28926. Lima, 8 de diciembre de 2006.

Congreso de la República: "Define y establece las políticas nacionales de obligatorio cumplimiento para las entidades del gobierno nacional" Decreto Supremo N° 027-2007-PCM. Lima, 25 de marzo de 2007.

Congreso de la República: Ley Orgánica del Poder Ejecutivo; Ley N° 29158. Lima, 20 de diciembre de 2007.

Congreso de la República: Ley de Presupuesto del Sector Público del Año Fiscal 2009; Ley 29289. Lima, diciembre de 2008.

Congreso de la República: "Plan Nacional de Capacitación y Asistencia Técnica en Gestión Pública para el Fortalecimiento de los Gobiernos Regionales y Locales" Refrendado por Decreto Supremo N° 021-2004-PCM. Lima, 29 de marzo de 2009.

Consejo Nacional de Descentralización: Lineamientos generales para el concurso público de selección de directores regionales sectoriales. Resolución presidencial N° 012-CND-P-2003. Lima, 31 de enero del 2003.

Consejo Nacional de Descentralización / Consejo Directivo: Plan Nacional de Descentralización 2004 – 2006. Lima, 2004.

Consejo Nacional de Descentralización: Plan de Transferencia Sectorial del Quinquenio 2005 – 2009. Resolución Presidencial N° 026-CND-P-2005. Lima, 29 de marzo de 2005.

Consejo Nacional de Descentralización: Resolución Presidencial N° 050-CND-P-2005 que aprueba la Directiva N° 03-CND-P-2005 "Normas para la ejecución de la transferencia del año 2005 a los gobiernos regionales y locales, de los fondos y proyectos sociales, programas sociales de lucha contra la pobreza, proyectos de inversión en infraestructura productiva de alcance regional y funciones sectoriales, incluidos en el DS N° 052-2005-PCM". Lima, 11 de agosto de 2005.

Consejo Nacional de Descentralización: Resolución Presidencial N° 065-CND-P-2005. Lima, 25 de septiembre de 2005.

Consejo Nacional de Descentralización: Resolución Presidencial N° 081-CND-P-2005 que aprueba la Directiva N° 05-CND-P-2005, "Procedimiento para la formulación de los planes de transferencia sectoriales de mediano plazo y de los planes anuales de transferencia de competencias sectoriales a los gobiernos regionales y locales" Lima, 24 de diciembre de 2005.

Consejo Nacional de Descentralización: Resolución Presidencial N° 044-CND-P-2006. Lima, 17 de mayo de 2006.

Dammert, Manuel: La democracia territorial, hacia la refundación nacional descentralista. Lima, 2001.

Decentralization; An overview. En: Sourcebook on Decentralization in Asia.

Ewig, Christina: The Politics of Health Sector Reform in Peru. Woodrow Wilson Center Workshops on the Politics of Education and Health Reforms. Washington D.C., April 18-19, 2002.

Falleti, Tulia: A Sequential Theory of Decentralization: Latin American Cases in Comparative Perspective. The American Political Science Review, Vol. 99, N° 3 (Aug., 2005): 327-346.

Gobierno Regional de Apurímac / Consejo Regional: Aprueba el reglamento de organización y funciones del Gobierno Regional de Apurímac; Ordenanza Regional N° OR N° 027-2005-GRA/CR. Abancay, 2005.

Gobierno Regional de Arequipa / Consejo Regional: Aprueban modificación de la estructura orgánica y del reglamento de organización y funciones del Gobierno Regional Arequipa; Ordenanza Regional N° 010-Arequipa. Arequipa, 14 de mayo de 2007.

Gobierno Regional del Callao / Consejo Regional: Ordenanza Regional que aprueba el reglamento de organización y funciones del Gobierno Regional del Callao; Ordenanza Regional N° 006. Callao, 11 de marzo de 2008.

Gobierno Regional de Huancavelica / Consejo Regional: Ordenanza que aprueba la modificación del reglamento de organización y funciones (ROF), estructura orgánica y cuadro para asignación de personal (CAP) del Gobierno Regional de Huancavelica y modificación del cuadro para asignación de personal (CAP) de las gerencias subregionales de Tayacaja y Huaytará; Ordenanza Regional N° 148-GOB.REG-HVCA./CR. Huancavelica, 29 de diciembre de 2009.

Gobierno Regional de Junín / Consejo Regional: Ordenanza Regional que deroga la Ordenanza Regional N° 095-2009-GRJ/CR y la Ordenanza Regional N° 099-2009-GRJ/CR; Ordenanza Regional N° 103-2011-GRJ/CR. Huancayo, 11 de enero de 2011.

Gobierno Regional de La Libertad / Consejo Regional: Aprueba la modificación de la estructura orgánica del Gobierno Regional La Libertad y consiguiente organigrama estructural, así como su reglamento de organización y funciones; Ordenanza Regional N° 023-2008-GRLL/CR. Trujillo, 14 de julio de 2008.

Gobierno Regional de La Libertad/ Consejo Regional: Aprobar la modificación del organigrama estructural y del reglamento de organización y funciones (ROF) de la Gerencia Regional de Salud de La Libertad; Ordenanza Regional N° 004-2011-GR-LL/CR. Trujillo, 18 de mayo de 2011.

Gobierno Regional de Lambayeque/ Consejo Regional: Aprueban la actualización del reglamento de organización y funciones del Gobierno Regional de Lambayeque; Ordenanza Regional N° 009-2011GR.LAMB./CR. Chiclayo, 20 de abril de 2011.

Gobierno Regional de San Martín / Consejo Regional: Aprueba reglamento de organización y funciones de la Dirección Regional de Salud de San Martín. Ordenanza Regional N° 027-2009-GRSM/PGR. Moyobamba, 14 de septiembre de 2009,

Gobierno Regional San Martín / Consejo Regional: Aprueba el reglamento de organización y funciones del Gobierno Regional San Martín; Ordenanza Regional N° 037-2010-GRSM/CR. Moyobamba, 14 de diciembre de 2010.

Guerra-García, G.; Arca, J. M.; Arguedas, C.; Minaya, V.: Hoja de ruta de la descentralización del sector salud. Lima, noviembre de 2004.

Guimaraes, Luisa: Modalidades de descentralización en el sector salud y sus contribuciones a la equidad: elementos fundamentales para la formulación de un marco normativo. OPS. Serie Informes Técnicos N° 76. Washington DC, septiembre, 2001.

Harrington, H.: Mejoramiento de los procesos de una empresa. Mc Graw-Hill. 1986.

Jaramillo, Martha: La descentralización: una mirada desde las políticas públicas y las relaciones intergubernamentales en Baja California. El Colegio de Sonora; Sonora, México. Región y Sociedad, Vol. XXII, núm. 49, 2010, pp. 177-200.

Javed, S.; Perry, G.; Dillinger, W.: Beyond the center; Decentralizing the state. The World Bank. Washington, D.C., 1999.

León, Ana M.; Balance del proceso de reorganización de salud en los gobiernos regionales. En: Taller de intercambio de experiencias sobre reorganización de las DIRESA en los gobiernos regionales. Ministerio de Salud / Oficina General de Planificación y Presupuesto. Tarapoto, 11 de junio de 2010.

Lister, S., and Betley, M.: Approaches to decentralization in developing countries. Capetown, June, 1999.

Ministerio de Economía y Finanzas / Dirección Nacional del Presupuesto Público: Directiva N° 010-2007-EF/76.01 para la programación y formulación del presupuesto de los programas estratégicos en el marco del presupuesto por resultados. Lima, 2007.

Ministerio de Salud: Lineamientos de política de salud. Lima, 1985.

Ministerio de Salud / Unidad Coordinadora de la Modernización del Subsector Público: Listado de compromisos SAL – HEALTH. Lima, febrero de 1999.

Ministerio de Salud / Dirección General de Salud de las Personas: Plan de Implementación de la Reforma de la Dirección General de Salud de las Personas. Documento de trabajo. Lima, abril de 1999.

Ministerio de Salud / Dirección General de Salud de las Personas: Reforma de la Dirección General de Salud de las Personas; nuevo diseño organizacional y nuevas funciones. Documento de trabajo. Lima, abril de 1999.

Ministerio de Salud / Dirección General de Salud de las Personas: Plan de Implementación del Programa Mujer, Niño y Adolescente. Lima, junio de 1999.

Ministerio de Salud / Dirección General de Salud de las Personas: Plan de desarrollo institucional de la DGSP. Documento de trabajo. Lima, agosto del 2000

Ministerio de Salud / Dirección General de Salud de las Personas: Lineamientos para la conformación de redes de salud. Resolución Ministerial N° 122-2001-SA/DM. Lima, 26 de febrero del 2001.

Ministerio de Salud: Resolución Ministerial N° 163-2001-SA/DM, Modifican artículos del Reglamento de Organización y Funciones del Ministerio de Salud. Lima, 14 de marzo del 2001.

Ministerio de Salud: Resolución Ministerial N° 343-2001-SA/DM, Modifican la Resolución Ministerial N° 163-2001-SA/DM que modificó el Reglamento de Organización y Funciones del Ministerio de Salud. Lima, 19 de junio del 2001.

Ministerio de Salud: Lineamientos de política sectorial para el período 2002-2012 y principios fundamentales para el quinquenio agosto 2001 – julio 2006. Lima, diciembre del 2001.

Ministerio de Salud / Dirección General de Salud de las Personas: Lineamientos estratégicos 2002 – 2006. Lima, 2002.

Ministerio de Salud: Resolución Ministerial N° 1125-2002-SA/DM. Directiva DGSP – DESS N° 001-05-2002 para la delimitación de Redes y Microrredes de Salud. Lima, 17 de julio del 2002.

Ministerio de Salud / Dirección General de Salud de las Personas: Plan operativo 2003. Lima, 2003.

Ministerio de Salud: Resolución Ministerial N° 573-2003-SA/DM. Aprueba reglamentos de organización y funciones de las direcciones de salud y de las direcciones de red de salud. Lima, 23 de mayo de 2003.

Ministerio de Salud: Resolución Ministerial N° 638-2003-SA/DM. Aprueba documento “Delimitación de las Direcciones de Salud, Direcciones de Red de Salud y Microrredes de Salud del Ministerio de Salud”. Lima, 3 de junio de 2003.

Ministerio de Salud: Resolución Ministerial N° 371-2003-SA/DM. Aprueba Directiva N° 007-2003-MINSA/OGPE-V.01 para la formulación de documentos técnicos normativos de gestión institucional. Lima, 4 de junio 2003.

Ministerio de Salud: Resolución Ministerial 638-2003-SA/DM. Delimitan las Direcciones de Salud, Direcciones de Red de Salud y Microrredes de Salud del Ministerio de Salud. Lima, 9 de junio del 2003.

Ministerio de Salud / Oficina de Descentralización: Informe “Reestructuración de los ámbitos de jurisdicción de las Direcciones de Salud en Lima”. Lima, abril de 2005.

Ministerio de Salud: Resolución Ministerial N° 405-2005/MINSA. Reconocen que las Direcciones Regionales de Salud constituyen la única autoridad de salud en cada Gobierno Regional. Lima, 30 de mayo de 2005.

Ministerio de Salud: Resolución Ministerial N° 452–2005–MINSA. Aprueban el “Plan Nacional de Capacitación de los Recursos Humanos del Ministerio de Salud 2005 – 2006”. Lima, 14 de junio de 2005.

Ministerio de Salud: Resolución Ministerial N° 566-2005-MINSA. Aprueban los Lineamientos para la adecuación de la organización de las Direcciones Regionales de Salud en el marco del proceso de descentralización. Lima, 22 de julio 2005

Ministerio de Salud: Resolución Ministerial N° 689-2005/MINSA. Reordenan ámbitos jurisdiccionales de las direcciones de salud de Lima. Lima, 14 de septiembre de 2005.

Ministerio de Salud: Resolución Ministerial N° 928-2005/MINSA. Aprueban directiva administrativa N° 071-MINSA/OGPE-VO1 “Medidas complementarias para el reordenamiento de los ámbitos jurisdiccionales de las DISAS de Lima; Lima, 3 de diciembre de 2005.

Ministerio de Salud: Resolución Ministerial N° 189-2006/MINSA. Aprueban Plan de Transferencia Sectorial 2006. Lima, 24 de febrero de 2006.

Ministerio de Salud: Resolución Ministerial N° 461-2006/MINSA. Aprueban directiva administrativa N° 084-MINSA/OE-VO1 “Medidas para la implementación del reordenamiento de los ámbitos jurisdiccionales de las DISAS de Lima – Segunda etapa”. Lima, 16 de mayo de 2006.

Ministerio de Salud / Oficina de Descentralización: Hoja de ruta para la descentralización de la función salud; actualización, avances y agenda pendiente. Lima, julio de 2006.

Ministerio de Salud: Resolución Ministerial N° 042-2007-MINSA. Documento Técnico “Descentralización de la Función Salud al Nivel Local; Los Proyectos Piloto” Lima, enero de 2007.

Ministerio de Salud: Resolución Ministerial N° 187-2007/MINSA. Aprueban Plan de Transferencia Sectorial 2007; Lima, 28 de febrero de 2007.

Ministerio de Salud: Resolución Ministerial N° 366-2007-MINSA. Aprueban “Documento técnico: Desarrollo de la función salud en los gobiernos locales”. Lima, 5 de mayo del 2007.

Ministerio de Salud: Resolución Ministerial N° 614-2007-MINSA. Aprueban “Guía de implementación de los proyectos pilotos de descentralización en salud a los gobiernos locales”. Lima, 1 de agosto del 2007.

Ministerio de Salud: Resolución Ministerial N° 043-2008/MINSA. Declaran en proceso de transferencia a la DISA Lima III y sus órganos desconcentrados al Gobierno Regional de Lima. Lima, 24 de enero de 2008.

Ministerio de Salud: Resolución Ministerial N° 067-2008/MINSA. Conforman grupo de trabajo encargado de la implementación de la LOPE en el Ministerio de Salud. Lima, 8 de febrero de 2008.

Ministerio de Salud: Autorizan transferencia de partidas del Ministerio de Salud al Gobierno Regional del departamento de Lima; Decreto Supremo N° 008-2008-SA. Lima, 13 de marzo de 2008.

Ministerio de Salud: Matrices de delimitación de competencias y distribución de funciones del sector salud. Lima, septiembre de 2008,

Ministerio de Salud: Resolución Ministerial N° 772-2008/MINSA. Declaran en proceso de transferencia a los órganos que integran la DISA I Callao al Gobierno Regional del Callao. Lima, 1 de noviembre de 2008.

Ministerio de Salud: Resolución Ministerial N° 003-2009/MINSA. Declaran que el Gobierno Regional del Callao ha culminado el proceso de transferencia de las funciones sectoriales en materia de salud. Lima, 10 de enero de 2009.

Ministerio de Salud: Resolución Ministerial N° 297–2009–MINSA. Aprueban el “Plan de transferencia sectorial 2009”. Lima, 7 de mayo de 2009.

Ministerio de Salud / Oficina de Descentralización: Matriz de distribución de funciones de salud a los gobiernos locales; versión de marzo de 2011.

Ministerio de Salud: Resolución Ministerial N° 175–2011–MINSA que aprueba el “Plan de transferencia sectorial 2011”. Lima, 15 de marzo de 2011.

Ministerio de Salud: Resolución Ministerial N° 184–2011–MINSA que aprueba el “Plan sectorial concertado y descentralizado para el desarrollo de capacidades en salud 2010 - 2014”. Lima, 15 de marzo de 2011.

Ministerio de Salud: Matriz de delimitación de competencias y asignación de funciones del sector salud en los tres niveles de gobierno; versión del 26 de mayo de 2011.

Ministerio de Salud: Matriz de delimitación de competencias y asignación de funciones del sector salud en los tres niveles de gobierno; versión del 6 de julio de 2011.

Molina, R.: Experiencias de Reforma Institucional en gobiernos regionales; Estudio de casos. Comisión de Descentralización, Regionalización, Gobiernos Locales y Modernización de la Gestión del Estado del Congreso de la República. Lima, octubre de 2010.

Palma, E.; Rufián, D.: La desconcentración administrativa y las prestaciones sociales. Instituto Latino Americano y del Caribe de Planificación Económica y Social. Santiago de Chile, 1993.

Peckham, S.; Exworthy, M.; Powell, M.; and Greener, I. (2005): Decentralisation as an organizational model for health care in England. NCCSDO. London.

Pereyra, Juan: Presentación de la experiencia del Gobierno Regional de Huancavelica en su reorganización institucional. En: Taller de intercambio de experiencias sobre reorganización de las DIRESA en los gobiernos regionales. Gobierno Regional de Huancavelica. Tarapoto, 11 de junio de 2010.

Poder ejecutivo: Ley de Organización del Sector Salud, Decreto Legislativo 70. Lima, abril 1981.

Poder ejecutivo: Ley de Organización y Funciones del Ministerio de Salud, Decreto Legislativo N° 584. Lima, 18 de abril de 1990

Poder ejecutivo: Ley del Poder Ejecutivo; Decreto Legislativo N° 560. Lima, 28 de marzo de 1990.

Poder ejecutivo: Reglamento de organización y funciones del Ministerio de Salud; Decreto Supremo N° 002-92-SA. Lima 20 de agosto de 1992.

Poder Ejecutivo: Autorizan transferencia de partidas en el presupuesto del sector público a favor de pliegos de los gobiernos regionales; Decreto Supremo N° 021-2003-EF. 20 de febrero de 2002.

Poder Ejecutivo: Transfieren diversos órganos del Ministerio de la Presidencia al Consejo Nacional de Descentralización; decreto supremo N° 018-2002-PRES. Lima, 1° de agosto de 2002.

Poder Ejecutivo: Transfieren los Consejos Transitorios de Administración Regional a la Presidencia del Consejo de Ministros; Decreto Supremo N° 020-2002-PRES. Lima, 1° de agosto de 2002.

Poder ejecutivo: Reglamento de la Ley N° 27657 - Ley del Ministerio de Salud. Decreto Supremo N° 013-2002-SA. Lima, 16 de noviembre de 2002.

Poder ejecutivo: Reglamento de organización y funciones del Ministerio de Salud. Decreto Supremo N° 014-2002-SA. Lima, noviembre de 2002.

Poder Ejecutivo: Establece disposiciones relativas a la culminación de las transferencias programadas a los gobiernos regionales y locales, disponiendo el plazo del 31 de diciembre de 2007; Decreto Supremo N° 068-2006-PCM. Lima, 13 de octubre de 2006.

Poder Ejecutivo: Establecen disposiciones relativas al proceso de transferencia de la gestión de la atención primaria de salud a las municipalidades provinciales y distritales. Decreto Supremo 077-2006-PCM. Lima, 30 de octubre de 2006.

Poder Ejecutivo: Aprueba el Plan anual de transferencia de competencias sectoriales a los gobiernos regionales y locales del año 2007; Decreto Supremo N° 036-2007-PCM. Lima, 12 de abril de 2007.

Poder Ejecutivo Crea y regula el Sistema Nacional de Planeamiento Estratégico y el Centro Nacional de Planeamiento Estratégico; Decreto Legislativo N° 1088. Lima, 20 de junio de 2008

Poder Ejecutivo: Aprueba normas de capacitación y rendimiento para el sector público; Decreto Legislativo N° 1025. Lima, 20 de junio de 2008.

Poder Ejecutivo: Crea la Autoridad Nacional del Servicio Civil, rectora del Sistema Administrativo de Gestión de Recursos Humanos; Decreto Legislativo N° 1023. Lima, 20 de junio de 2008.

Poder Ejecutivo: Crea y regula el cuerpo de gerentes públicos; Decreto Legislativo N° 1024. Lima, 20 de junio de 2008.

Poder Ejecutivo: Establece un régimen especial facultativo para los gobiernos regionales y locales que deseen implementar procesos de modernización institucional integral; Decreto Legislativo N° 1026. Lima, 20 de junio de 2008.

Poder Ejecutivo: Proyecto de Ley de Organización y Funciones del Ministerio de Salud. Comunicación al Congreso de la República. Lima, 25 de Julio de 2008.

Poder Ejecutivo: Decreto supremo que dicta disposiciones para la aprobación de las matrices de delimitación de competencias y distribución de funciones de los ministerios que tienen a su cargo competencias exclusiva y compartida; Decreto Supremo N° 049-2009-PCM s. Lima, 23 de julio de 2009.

Poder Ejecutivo: Aprueban reglamento para la transferencia de recursos humanos del gobierno nacional a los gobiernos regionales y locales; Decreto Supremo N° 040-2010-PCM. Lima, 28 de marzo de 2010.

Presidencia de la República: Decreto Supremo N° 080-2004-PCM; Reglamento de la Ley N° 28273 - Ley del Sistema de Acreditación de los Gobiernos Regionales y Locales. Lima, 16 de noviembre del 2004.

Presidencia de la República: Plan anual de transferencia de competencias sectoriales a los gobiernos regionales y locales del año 2005. Decreto supremo N° 052-2005-PCM. Lima, 28 de julio de 2005.

Presidencia del Consejo de Ministros: Decreto Supremo N° 012-1-90-PCM, aprobó la directiva de transferencia de funciones, personal y diversos recursos a los gobiernos regionales. Lima, 1990.

Presidencia del Consejo de Ministros: Aprueban el “Plan Anual de Transferencia de Competencias Sectoriales a los Gobiernos Regionales y Locales 2006”. Decreto Supremo N° 021-2006-PCM. Lima, 27 de abril de 2006.

Presidencia del Consejo de Ministros: Lineamientos para la elaboración y aprobación del reglamento de organización y funciones (ROF) por parte de las entidades de administración pública; Decreto Supremo N° 043-2006-PCM. Lima, 21 de julio de 2006.

Presidencia del Consejo de Ministros: Decreto Supremo N° 027-2007-PCM define y establece las Políticas Nacionales de obligatorio cumplimiento para las entidades del Gobierno Nacional. Lima, 22 de marzo de 2007.

Presidencia del Consejo de Ministros / Secretaría de Descentralización: Resolución Presidencial N° 003-2007-PCM/SD que aprueba la Directiva N° 001-2007/PCM-SD “Normas para ejecución de la transferencia del año 2007 a los gobiernos regionales y locales, de las funciones sectoriales incluidas en los Planes de Transferencia”. Lima, 17 de mayo de 2007.

Presidencia del Consejo de Ministros / Secretaría de Descentralización: Resolución Presidencial N° 025-2007- PCM/SD que aprueba la Directiva N° 006- 2007/PCM-SD “Normas para la efectivización del proceso de transferencia del año 2007 de los sectores del gobierno nacional a los gobiernos regionales”. Lima, 25 de septiembre de 2007.

Presidencia del Consejo de Ministros: Decreto Supremo N° 002-2008-PCM, crea la Comisión Multisectorial para el Desarrollo de Capacidades en Gestión Pública de los Gobiernos Regionales y Locales. Lima, 14 de enero de 2008.

Presidencia del Consejo de Ministros: Resolución Ministerial que aprueba la elaboración de las Matrices de delimitación de competencias y distribución de funciones y los ante proyectos de LOF de los ministerios que tienen a su cargo competencias exclusiva y compartidas.; Resolución Ministerial N° 188-2008-PCM. Lima, 13 de junio de 2008.

Presidencia del Consejo de Ministros: Aprueba Directiva “Lineamientos para la elaboración de Proyectos de Leyes de Organización y Funciones de los Ministerios que tienen a su cargo únicamente competencias exclusivas; Resolución Ministerial N° 111-2008-PCM. Lima, 10 abril de 2008.

Presidencia del Consejo de Ministros / Secretaría de Descentralización: Extiende vigencia de la Directiva N° 001-2007/PCM-SD que norma y regula la transferencia de funciones sectoriales a los gobiernos regionales a las comprendidas en el Plan de Transferencia 2008; Resolución de Secretaría de Descentralización N° 060-2008-PCM/SD. Lima, 14 de noviembre de 2008.

Presidencia del Consejo de Ministros / Secretaría de Gestión Pública: Informe de Reunión de trabajo para la presentación de avances en el proceso de validación de las matrices y clarificación de la estrategia a futuro para la culminación de este proceso. Lima, 7 de julio de 2009.

Presidencia del Consejo de Ministros / Secretaría de Descentralización: Plan anual de transferencias sectoriales a los gobiernos regionales y locales del año 2009; Decreto Supremo N° 047-2009-PCM. Lima, 23 de Julio de 2009.

Presidencia del Consejo de Ministros / Secretaría de Gestión Pública: Guía metodológica complementaria para el análisis de las matrices de delimitación de competencias y distribución de funciones sectoriales. Lima, julio de 2009.

Presidencia del Consejo de Ministros: Decreto Supremo N° 047-2009- PCM, aprueba el Plan Anual de Transferencia de Competencias Sectoriales a los Gobiernos Regionales y Locales del año 2009, y otras disposiciones para el desarrollo del proceso de descentralización. Lima, 23 de julio de 2009.

Presidencia del Consejo de Ministros / Secretaría de Descentralización: Aprueba Directiva 004-2009-PCM/SD “Directiva para la transferencia de fondos, programas, proyectos, empresas, infraestructura y otros instrumentos operativos asociados a las funciones transferidas a los gobiernos regionales y locales, y la utilización de la delegación de competencias entre niveles de gobierno, en el marco del proceso de descentralización; Resolución de Secretaría de Descentralización N° 059-2009-PCM/SD. Lima, 12 noviembre 2009.

Presidencia del Consejo de Ministros: Decreto Supremo N° 004-2010- PCM, aprueba el “Plan Nacional de Desarrollo de Capacidades para la Gestión Pública y Buen Gobierno de los Gobiernos Regionales y Locales”. Lima, 11 de enero de 2010.

Presidencia del Consejo de Ministros: Resolución de Secretaría de Descentralización N° 154-2011-PCM/SD, que aprueba la Directiva N° 001-2011-PCM/SD: “Directiva general para la formulación, aprobación, implementación, monitoreo y evaluación de los planes de desarrollo de capacidades”. Lima, 11 de marzo de 2011.

Prud'homme, Remy: On the dangers of decentralization. Policy research working paper 1252. The World Bank. Washington D.C., 1994.

Summers, Michael R.: Analyzing Operations in Business; Issues, Tools & Techniques. Greenwood Press. Westport, CT, USA, 1998.

Tamayo, Manuel. 1997. El análisis de las políticas públicas. En: “La nueva administración pública”, compilado por Rafael Bañón y Ernesto Carrillo, 281-311. Madrid: Alianza Universidad.

Távora, Gerardo y Márquez, Jaime: Sistematización del proceso de descentralización del sector salud. Promoviendo alianzas y estrategias, Abt Associates Inc. Lima, marzo de 2009

Ugarte, Mayen; Arguedas, Cinthya: Modelo de descentralización en salud para el nivel local. Promoviendo alianzas y estrategias, Abt Associates Inc. Lima, 2007.

Ugarte, O. y Bardález, C.: Proceso de descentralización en salud. Promoviendo alianzas y estrategias, Abt Associates Inc. Lima, Lima, 2006.

Ugarte, Oscar: Descentralización en salud. En: Políticas de salud 2001 – 2006. Consorcio de Investigación Económica y Social. Lima, julio del 2001.

Uribe, Gilda: Segundo informe de consultoría; Monitoreo y revisión del proceso de validación de las matrices de funciones y los proyectos de ley de organización y funciones de los Sectores del Gobierno Nacional para la delimitación de competencias entre los tres niveles de gobierno. Lima, mayo de 2010.

World Bank: Decentralization, rethinking government. In: World Development Report 1999/ 2000. 2000. Capítulo 5.